

Access and Inclusion of Children (0-8) and their Families in Moree, NSW



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Acknowledgements

The report author would like to acknowledge the time given by the various project participants whose contributions have helped influence the quality of the report. The support of Terri Mears, Manager –Research at Northcott, was extremely beneficial in the design and direction of the project. The report author acknowledges the support of Wayne Nagle of the Northcott office in Moree for his advice on the area and an understanding of services in Moree. Dr. Kath McKay, Research Fellow at the School of Health, University of New England, provided invaluable support in the analysis and discussion of this project. The time, which was voluntarily given by the participants, was greatly appreciated. Finally, thank you to Ageing Disability and Home Care (ADHC) for the funding the project.

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Executive Summary

This report outlines the findings from a project, which considered the impact of inclusion and access for children (0-8) and in their families in the regional New South Wales town of Moree. The following questions are investigated and answered:

1. How are issues of access and inclusion experienced by children (aged 0-8 years) and their families with regards to services (including schooling) and infrastructure (including parks and social activities) within a rural NSW community?
2. What challenges exist with regards to developing and providing accessible and inclusive services in an outer-regional NSW town?

Background

The geographical focus of this report is the town of Moree (NSW), which the Australian Bureau of Statistics has highlighted as a town with a large population decline (2001-2011). Many services, both governmental and non-governmental, have provided, and continue to provide, support to the Moree Shire Community. However, there are questions around the availability and accessibility of services for children aged 0-8 years. The provision of adequate support to towns in regional areas of Australia is a perennial issue for both state and federal governments and this is especially true when population decline and the distance from a regional centre is factored in.

Northcott, one of the commissioners of this report (along with NSW Department of Family and Community Services, Ageing, Disability and HomeCare (ADHC), has a strong presence in the Moree community and is one of the larger service providers.

Current Situation

The effectiveness, availability, and accessibility of services for the report's target population of children (0-8), and their families, was the main focus of this report. There is a dearth of research with regards to this particular age group and this report considered more general research regarding access and inclusion in rural communities. A decrease in population while the demand for services is maintained or increased puts a strain on resources in communities such as Moree. This can be cyclical in nature in that a lack of services (perceived or not) means people leave, which can decrease the number of services considered necessary to maintain, and so, again, people leave. Of course, this same situation can be exacerbated with people not moving into the community. As a result of this situation, the recruitment of skilled

staff for various services, such as those within education and health, may be difficult. Therefore, difficulties with providing services might not be a purely financial issue, as there are situations where funding is available but it has not been possible to attract the skilled staff required for the organisation to operate effectively.

The Dew model (see the section *Rural Communities and Services* in Chapter One) creates a health practice structure whereby para-professionals live within the area of service provision but can be remotely supervised by fully-qualified professionals in a more central location. This practice model could be especially helpful when members of the 0-8 population are required to seek a medical professional able to provide an appropriate level of service to their needs. The lack of paediatric specialist support in the Moree area has led to reports of patients traveling to towns several hours away, such as Tamworth, in order to gain access to a specialist in a reasonable timeframe.

Methodology Utilised in this Study

Fourteen structured in-depth interviews were conducted within two broad groups – ten community leaders and service providers (including schools), and four parents of children aged 0-8 years with additional support needs. The questions focused on access and inclusion for children aged 0-8 years and their families in Moree.

These interviews were then explored using three-stage interpretive thematic analysis: 1) notes were taken to uncover a global sense of the experiences uncovered; 2) the interviews were then coded into broad themes; and 3) these broad themes were then analysed interpretively to uncover finer narratives – how specific issues were spoken about by participants and the nuances of interwoven stories. Pseudonyms were given to all participants apart from the Mayor who acknowledged that she would not be able to be left anonymous, given her position, and agreed that her name be kept the same.

Results and Discussion

Eight themes were discussed:

1. Issues of perceptions

The impact of the negative portrayals of Moree was perceived to impact service provision, migration, tourism, and community morale.

2. Services currently in Moree to support children aged 0-8 years

Currently there are around 68 separate services provided in Moree, yet parents reported uncertainty around what was available at any point in time.

3. Facilities and infrastructure

Participants spoke about a lack of things to do in Moree that were appropriate for their children. Places to eat as a family and a cinema were the two most commonly cited issues.

4. Inclusivity with kindergartens/preschools and schools

There were many positive aspects to the work done by the kindergartens/preschools and schools in terms of accessibility and inclusivity of children aged 0-8 years. However, this could depend on the individual teacher and training was seen as a priority.

5. Perceptions and experiences of access and inclusion among the Aboriginal community

Moree was seen to have become more inclusive. However, there were still concerns around children missing out on services due to the expense or travel required, or that people didn't know who to ask for support or how to ask for help.

6. Experiences of social isolation

Parents spoke about the practical difficulties in going out as there was so much to organise and they could not be certain at first as to whether or not the activity really would be appropriate. Some parents had borne the brunt of inappropriate comments and behaviours.

7. Impacts of funding issues on the provision of services

Short-term funding did not allow for long-term planning or for projects to necessarily continue after the funding period. This created uncertainty among staff and community members, as well as mistrust between services.

8. The small things with big impacts

Parents spoke about people in the community, whose work helped their child but was not necessarily recognised as a ‘service’. The broken wheelchair swing was also mentioned as something that now excluded a child from the playground.

Recommendations for Access and Inclusion in Moree

Overall, there are various suggestions for improving access and inclusion in Moree. However, there were many positives, put forward by the participants, such as that of the encouraging views vis-à-vis the support and facilities provides at preschool. There are areas that might warrant consideration, and these were found to be around that of service provision and coordination. A theme, which consistently came across from the interviews, were that of the lack of understanding of which service provided which support. It was clear that some sort of overseer is required in order to maximise the quality of the services being provided within the Moree Shire area.

This report puts forward seven recommendations in order to address the issues in this report regarding *Access and Inclusion of Children (0-8) and their Families in Moree* and these are set out as follows:

1. There is a need to understand what organisations exist in Moree and the services they provide
2. There is a need for greater coordination of services in the Moree community
3. Funding to services needs to be ongoing
4. Funding needs to also include infrastructure
5. ‘Disability’ needs to be understood in all its variations and nuances
6. Accessibility and inclusivity is not just bound to health, but to quality of life
7. The need to improve access to therapy services in a rural community

Introduction

This study was commissioned by the NSW Department of Family and Community Services, Ageing, Disability and HomeCare (ADHC), and Northcott, which is a not-for-profit organisation that provides services to people with disability, their families and carers across NSW and the ACT. The project will consider issues around access and inclusion of children in the age range 0-8 years, and their families in the New England (NSW) town of Moree. This project involved a literature review and interviews with key stakeholders in Moree. These stakeholders included the parents/guardians of children aged 0-8 years, school principals, service providers, and community leaders (Aboriginal community Elders and the Moree Plains Shire Council Mayor). This research project was approved by the University of New England Human Research Ethics Committee (Approval Number: HE15-014).

The research that currently exists around issues of access and inclusion of children aged 0-8 years (and their families) is sporadic, with many studies focussing on a particular disability issue or an age range that involves older children. Indeed, there is a dearth of research on children younger than five years of age. Knight and colleagues conducted a qualitative literature review examining factors that impacted on how and whether children and young people with a physical disability accessed out-of-school activities in the UK. Based on nine papers, this literature review acknowledged that there was a lack of research around this area and the voices of children and young people were rarely heard within this space. Here, social inclusion was defined as “...joining in the activities of their choice and having the right to participate fully in their community” (Knight et al., 2014, p. 280; see also Barnardos, 2015). In their review, Knight and colleagues found that this desire to ‘fully participate’ often manifested in a desire to participate in mainstream activities – this was essentially a desire to be ‘like other kids’. In this way, there was a sense of trying to understand how mainstream services and infrastructure could accommodate these children’s desires to be included within them. For example, inaccessible public transport meant that children did not always have a choice as to which activities they did – they had to choose based on ability to get to the place where the activity would be undertaken (Lawlor et al., 2006). In another example, an accessible place (such as a playground) might lack accessible infrastructure (such as a wheelchair accessible swing) (Bennett, 2009). Given the gaps in our current knowledge around how access and inclusion are experienced by children aged 0-8 years (and their families), and how access and inclusion are practised in an outer-regional community by service providers and community leaders, this project sets out to provide an opportunity for these voices to be heard in a study situated in the outer-regional town of Moree, NSW. Both

recipients and providers of services have important narratives which inform what services and infrastructure are effective and appropriate for different groups within this larger population, and what else is needed to ensure a positive quality of life for children who may otherwise be invisible.

Research Questions

Based on the parameters of the project, the literature review and the subsequent analysis answers the following questions:

1. How are issues of access and inclusion experienced by children (aged 0-8 years) and their families with regards to services (including schooling) and infrastructure (including parks and social activities) within a rural NSW community?
2. What challenges exist with regards to developing and providing accessible and inclusive services in an outer-regional NSW town?

Chapter 1 - Literature Review

Demographics and Context

As demonstrated by the research questions, the population focussed upon in this project was children aged 0 to 8 years in the town of Moree in New South Wales (NSW), which is part of the Moree Plains Shire Council, with a more specific focus on their experiences of access and inclusion in the community. According to the Australian Bureau of Statistics (ABS, 2015), the population of the Shire is just over 14,000 (latest estimate), with around 20% identifying as being Aboriginal or Torres Strait Islander. The ten-year statistics from ABS (see Table 1) indicate a decline in population of 6%, whilst the NSW population as a whole has grown by 13% over the same period. However, it should be noted that the population groupings of children in the 0-4 and 5-9 age groups in the Moree Shire were higher than the NSW and Australian average by area (ABS, 2015).

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	Diff (%)
Moree PS	15028	14693	14407	14155	14070	14019	14032	14043	14175	14248	14092	-936 (-6.2%)
NSW	6.65m	6.69m	6.74m	6.83m	6.94m	7.05m	7.14m	7.22m	7.31m	7.41m	7.51m	+0.87m (13.0%)

Table 1 – Moree Plains Shire Population 2004-2014 (ABS, 2015)

According to the ABS, few communities in NSW have experienced a population decline, so even a 6% decrease, which equates to 936 people, is potentially significant. However, when the Moree Shire's rurality dimension is considered, its decline becomes less unexpected. The ABS (2011b) states that: *"Reflecting the effects of drought in many parts of rural NSW, more than half of these predominantly rural areas had population declines in the ten years to 2011"*. Further, the ABS specifically points out that, with regards to inland areas between 2001 and 2011, "the largest declines over this ten year period were in Broken Hill (down 2,000 people) and Moree (down 1,500)" (ABS, 2011b). Yet, these population declines (however numerically small) impact on service provision in tangible ways. In order to have a reasonable number of services – including entertainment, education, amongst other useful provisions – a reasonable population is needed. If the population declines, then the profitability for many businesses becomes more difficult; a continual decline of an area's population therefore not only puts pressure on services, but also discourages businesses from starting in the town (see further discussion later in this review, as well as in the Results and Discussion Chapter). This effect can be cyclical and intervention may be required by state government to arrest declines of this type. According to the Australian Standard Geographical

Classification (ASGC), 81.8% of the Moree Plains Shire's population is located in Outer Regional Australia, with 18.2% located in Remote (AIHW, 2014). This demonstrates that Moree is potentially vulnerable to population decreases and the resultant negative impacts on service delivery. Previous research has highlighted that service availability can decrease as remoteness increases in Australia (McKay et al., 2012).

The ABS's Socio-Economic Indexes for Areas (SEIFA; ABS, 2011a) places Moree in the second decile: there are ten groupings in the SEIFA with the highest numerical group (10) indicating the most advantaged community and the lowest (1), the most disadvantaged. Postcodes are used to indicate geographical areas. According to the SEIFA, Moree can be regarded as an area experiencing significant disadvantage. In light of this significant disadvantage, and acting as another indication that support is important and necessary for many in the population, there are a number of support services within the Moree Shire. However, it needs to be acknowledged (and will be explored later in the Results and Discussion chapter) that the number of services available in a community is not an indicator of their quality, appropriateness, or whether members of the community perceive them to be useful. What the number of services indicate is that the population of Moree Shire is recognised as being in need of various types of support by different levels of government.

Here it must be noted that research in this area has included children and young people of varying ages and that 'young people' has stretched to 19 years of age in some studies (see Welsh et al., 2010). There is little that has included experiences of children younger than five years of age, and these have (obviously) been narrated by their parents (see Bennett, 2009; Sloper et al., 2009). As a result, the findings presented here are limited in that some studies include a wide age group – for example, one study explored experiences of children aged between 7 and 19 years (Knight et al., 2009), and another examined children aged between 0-19 years (Bennett, 2009), which both cover significant developmental, social, and educational milestones and differences. In this way, there needs to be a greater contextualisation of age within studies which recognises that – as well as acknowledging the myriad diversity among children in general – young children will have very different needs and desires around access to and inclusion within services and infrastructure than children closer to being defined as 'adult'.

Rural Communities and Services

Indeed, in line with the significant concern around service provision in regional and remote NSW (and Australia), there has been a recent research focus on understanding how best to support the workers in these communities, and ensure retention. The Survey of the Rural Allied Health Workforce in New South Wales to Inform Recruitment And Retention (Keane et al., 2011) was an extensive survey of 1,879 health staff (nursing, medical, and allied health). The findings suggested that in rural NSW there is an experienced group of staff but over 50% are expected to retire within the next 5-10 years, which is an issue across any rural area, and Moree Shire is no exception. This lack of ‘succession planning’ is a concern for future health service provision and Keane et al. suggest that a failure to recruit younger staff may be an issue in rural areas, which should be addressed without delay. Further, the gradual decrease in staff coupled with the same (or increasing) service provision requirements heightens health staff’s vulnerability to ‘burn out’, which is another concern highlighted in the report. If this pattern continues, it could reasonably be argued that staff recruitment and retention in the Moree Shire, which is already problematic for many services, may continue to tangibly affect the future population in terms of attrition of the general population as well as that of service providers.

In their review on the access and inclusion issues experienced by children with a physical disability, Knight and colleagues found that the way in which activities were run (often by volunteers) impacted on whether parents and children found these activities to be inclusive. Here, staff training was vital in ensuring confidence in activity delivery which made the children and young people feel safe and welcome (Beresford et al., 2010), where their disability was not something that was difficult to deal with or out-of-the-ordinary (The Bevan Foundation, 2010). However, any positive outcomes from training will arguably be more likely to be lost if staff turnover is high – new staff will not have the same level of skill (and degree of contextualised understanding) as experienced staff which may lead to a less inclusive experience for children requiring support.

Indeed, children aged 0-8 years may be most vulnerable if they lack of access (or have problematic access) to reasonable healthcare, including access to specialists. These children are reliant on others for their healthcare (either parents or guardians) as they are simply not able to access it by themselves. Further, some families whose children have disabilities will

require more (and consistent) access to specialist health care than others. The child's needs will not disappear simply because a service has left the community.

In line with this, the survey by Keane and colleagues (2011), and the review of therapy provision for people with a disability in Australia (Dew et al., 2012), suggests that there are actual and potential issues with gaining access to suitable health care provision. Dew and colleagues (2012) discuss an important issue regarding how best to deliver essential therapeutic services to regional and remote Australian populations. They recognised that there is no getting away from the factor of distance, in that there are many people living in rural communities, varying in travel distance from a couple of hours to that of days from some form of service centre or hub. Consequently, Dew and colleagues (2012) suggest that, in order to provide the best service to rural communities, the use of local staff, who are in effect para-professionals, and who would also be under the guidance of fully-qualified hub staff, needs to be considered. For example, in Moree, the Dew model would mean that local personnel would be recruited and, in some cases, trained from scratch to operate as assistants to a fully-qualified health professional. In this way, Dew and colleagues suggest that even remote communities would be able to have more regular access to therapeutic intervention. In Moree, this model could directly benefit the population of children aged 0-8 years as there may be less of a need to travel further in order to receive adequate foundational therapeutic input (issues discussed extensively by the participants of this study and can be seen in the Results and Discussion chapter). However, the model suggested by Dew would not increase the access to specialists but only that of assistants. This could mean that, in a town such as Moree, the model would only improve access to less complex ongoing care. Access to specialists who could diagnose and treat more serious issues may not improve in the short-term.

In another systematic review, Green et al., (2014) considered there needs to be a "...shift towards inter-sector collaboration" (p.14) that transcends the boundaries between education, health, and social work services. This type of suggestion supports approaches that attempt to identify issues with, and thereby improve, service delivery (e.g. Keane et al., 2011; Dew et al., 2012), which is a much vaunted difficulty affecting many Australians in rural communities. The review by Green and colleagues (2014) specifically considered issues with providing services to Aboriginal and Torres Strait Island communities but the suggestions are relevant for this report due to the focus on providing services to children in rural Australian

communities, as well as the large percentage of Aboriginal and Torres Strait Islander people living in the Moree Shire. Of course, any attempt to move across different sectors, as suggested by Green et al., will be problematic as there are often barriers in existence to working across different service sectors, such as education, health and social services. The important point across these studies is working effectively across different services, systematically, may have flaws regarding how to provide a service and that is especially relevant for children aged 0-8 years and their families. Early intervention, whether it be in education or health, is universally regarded as necessary and Green et al., states “...that intervening at early stages of childhood development is more cost effective than intervening later in life” (2014, p. 2). It follows that lack of access to appropriate services in any town may have an impact on the successful development of young people

Issues of Access and Inclusion

This study focuses on access and inclusion for children aged between 0-8 years, some of whom will have additional support needs. In the research to date, ‘additional support needs’ has been conceptualised and defined in varying ways, but with a focus on intellectual and physical disabilities. However, there can be issues around the implications of labels. The notion of additional support is on a continuum and can range from requiring temporary support; for example, post-hospital care to more permanent disability. According to Boyle (2014), the provision of a label, in a disability context, serves the primary purpose of providing reasonable access to extra support in whatever format this may take. For children, having a label may provide more straightforward access to services but the long-term ramifications of receiving a label may potentially present social inclusion difficulties later in life, as an adolescent and subsequently in adulthood.

Problematic inclusion can lead to fewer opportunities in the community, which can include challenges with schooling and access to services, which can impact later on employment. As briefly explored earlier, the concept of inclusion is widely known from both educational and from wider community aspects of society. From an education perspective, the notion of inclusion means that all students should have the right to access their local mainstream school (i.e., be fully supported in their local school) no matter their difficulties (see Boyle et al., 2011). Outside of education, the term is more broadly recognised as that of social inclusion and reflects various aspects of having access to, and being included, at various levels of the community (Topping, 2012). The situation where students with additional support needs are

prevented from attending their local mainstream school – thereby taking them out of their school community which is a foundational one for the children who are the focus of this study – is quite clearly not inclusive. However, sometimes a lack of access to services can be more subtle: it can mean that people are excluded from various aspects of the community. Inequality can take many forms but in various parts of Australia, “...despite decades of prosperity, inequality remains a central feature of social life...” (Habibis & Walter, 2015, p. 254). In many rural communities, access to appropriate services and the existence of inclusive infrastructure may be difficult to attain for the population as a whole, let alone those in the community who require more sophisticated support. In some ways, a more accurate description of the situation may be that of a community experiencing disadvantage. Here, the position of Moree within SEIFA becomes an important reference.

In the state of Victoria, Australia, the London Mallee Region Primary Care Partnerships (LMRPCP; Sallie, Merrett, & Hogan, 2015) produced a report entitled *Building Socially Inclusive Rural Communities: A Complete Resource*. This report highlighted that “...there still remains a widening inequality in which rural people are disproportionately impacted” (2015, p. 4). At the same time, two other resources came from the same project: *Rural Social Inclusion: The Evidence* (Lavery, 2015), and *Building Socially Inclusive Rural Communities: The Framework* (LMRPCP, 2015). While the nature of the terms ‘social inclusion’ and, by extension ‘social exclusion,’ are complex and difficult to define in absolutes, Lavery (2015) suggested that by being able to gain access to resources and services within a community is part of being included, whereas not gaining access indicated exclusion. Social inclusion is a fluid term and, as Table 2 indicates, there are many more facets than just that of services and resources. Being part of an ethnic minority, or not having access to child care, may mean that person may be socially excluded, and thus isolated, despite many services or resources being available. As is discussed in the next section, being excluded and not being able to access the community either socially or through services is a clear sign of societal exclusion.

Despite the SEIFA metrics, the notion of what constitutes poverty remains difficult to define - it may not always be a lack of income, as it is normally understood. For example, Habibis and Walter (2015) report a case of a charity in Western Australia (FoodBank) becoming aware of double-income families being unable to purchase food. In this way, unemployment is clearly not the only reason someone might be economically excluded from facets of community involvement. In Australia, “the top 20% of people have 71 times as

much wealth as the bottom 20%” (Habibis & Walter, 2015, p. xiii). It may not be absolute poverty but certainly it is relative and whether a person is in employment or not may no longer be an indicator of relative poverty. In Moree, while SEIFA and other ABS statistics may indicate that some people are disadvantaged economically (and in other ways), social exclusion, disability, access, and ethnicity are all also relevant and important factors when considering inclusion and access to services for children (0-8 years) and their families in Moree, NSW.

In Moree, as with many NSW rural towns, there are examples of relative poverty. As Table 2 depicts, people classified within the disability and Aboriginal and Torres Strait Islander groupings, throughout the whole of Australia, were vulnerable to indicators of social exclusion, which can impact access to various aspects of community support. However, as with any demographic measure, what constitutes community involvement is open to debate and will vary between and within each of the classifications labelled in Table 2. Further, as per Table 2, 32% of people with a disability “did not participate in community services” and 35.1% had “no regular contact with other people”. These are both significant proportions of the disabled population, and indicate a direct possibility that within Moree, this type of exclusion will affect many people.

Indicator of Exclusion	Sole Parent Families %	Unemployed People %	People with a disability %	Indigenous Australians %
No Regular contact with other people	29.5	29.2	35.1	22.6
Did not participate in community activities ¹	28.8	44.3	32	31
Could not go out with friends and pay their way	61	64	61.5	51.3
No child care for working parents	74	74.7	78.2	70

Table 2 – Comparative Selected Indicators of Exclusion across Australia (Habibis & Walter, 2015, p. 87).

If we consider that generally people within the area may also fit in multiple categories, such as “sole parent families”, “unemployed”, and “people with a disability”, then it is possible to envisage significant issues with access to services and inclusion in the wider community. To extend this even further, the issues that may affect people who are economically excluded can affect access to other provisions within the community. For

¹ It should be noted that the concept of participating in the community was general and did not seem to specifically take into consideration community activities within the Aboriginal community

example, sports for children (0-8 years) can be expensive: even a modest charge can be regarded as significant if a family has limited finances, or more than one child. In situations such as this, it seems reasonable to suggest that there is an issue with inequality. Habbis and Walter (2015, p. 254) suggest that “policy decisions are a powerful influence on the contours of inequality...[they are] formulated on the basis of particular sets of values and beliefs...” It follows that certain decisions made by service providers, and various levels of government, can restrict or, indeed, open access to certain services and infrastructure. As also discussed in the Results and Discussion Chapter, the allocation of limited resources is always going to be fraught with difficulty when trying to match the needs of people with the amount of resources available.

Further, as with poverty, the nature of disadvantage is also hard to describe, as it is not always based in economics. Wolff and De-Shalit (2007) suggest that, when there is overt disadvantage in a geographical area, then the government should prioritise this area over all others. In essence, in the context of the present study, and as discussed earlier in this chapter, this comes in the form of services provided by various organisations. It seems that there are around 70 organisations providing services to a population of approximately 14,000 people in the Moree Plains Shire. However, while this may seem a significant number, as will also be explored in the Results and Discussion Chapter, there seems to be little coordination as to ensuring that the providers are not overlapping with others. As Wolff and De-Shalit indicate, the solution is very often not about redistribution of wealth or massive expenditure. The latter is too simple. The solution is about the quality of provision: using resources effectively, understanding what is needed, and satisfying demand for support. Money is necessary, of course, but distributing money, through services, in an uncoordinated way will ensure that vital funds are not adequately or appropriately spent. Funding, no matter how generous, without a proper and considered understanding of need, is wasteful and unproductive and does not progressively contribute to community improvement. This project will specifically consider the issue of service coordination.

Perceptions and Service Impact

The reputation of a community is important to attract businesses and encourage people to migrate to the area. As will also be explored in the Results and Discussion Chapter, focussing on the negative in rural Australian towns, such as Moree, may not be difficult. Arguably, any town in any state or territory in Australia could be portrayed in a positive or negative light

depending on the slant of the image creator. However, a negative portrayal, particularly in the media, can affect the psyche of a town and directly impact its residents, some of whom strive to improve the quality of life for the community as a whole. Further, the viewer and/or the reader are left to the pretexts of the presenter of the story, and this can be either constructive or otherwise. People from outside the area of Moree, or who have not visited, may be presented with a narrow picture of a town, and this may be the only information they are subjected to, on which they may subsequently base an erroneous negative judgement.

As is depicted in Figure 1, it is possible that the reputation of any town may negatively affect its population, as fewer people coming in means that fewer services and opportunities exist, which means more people may envisage the need to leave the community.

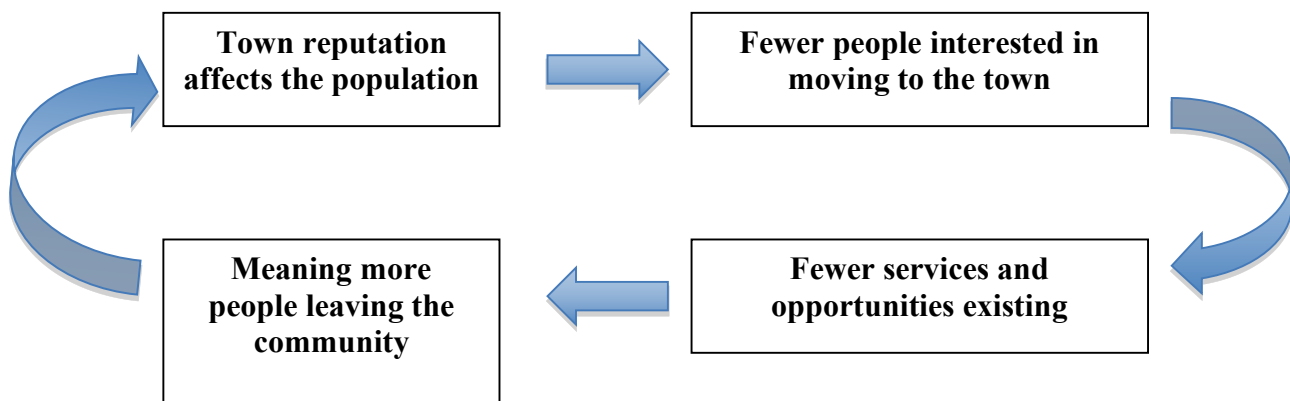


Figure 1 – The Cyclical Nature of the Effect of Population Decline

In this way, stigma pervades and tangibly impacts on service provision in a more social sense. As explored in the Results and Discussion chapter, there was a sense that negative media portrayals meant businesses were more reluctant to invest in Moree; yet they would invest in other communities facing similar challenges but that had not been under media spotlight. This meant that the Moree community missed out on services that could have improved their quality of life. As demonstrated in the Results and Discussion chapter, access to health services was not the only concern shared by the parents of children aged 0-8 years.

Chapter 2: Methodology

There are complex and multi-layered experiences connected to access and inclusion of children aged 0-8 years with and without additional support needs. Firstly, the needs of these children cannot necessarily be considered separate to the practical lives of their parents and carers – the child cannot access a resource entirely on his/her own. Secondly, it was decided that these children were too young to be separately included as participants in the data collection. Consequently, in order to obtain the most holistic amount of knowledge around access and inclusion as possible, children remained the focus of the project as participants who were chosen were either parents or had some practical experience in running, or making decisions around access and inclusion within the community.

Funded by ADHC, it was decided that the most appropriate methodological approach in which to ground this study was one that was community-led and community-grounded. As explained earlier in this report, this study aimed to understand issues around accessibility and inclusivity of all children from two perspectives: community leaders and service providers, and the parents of these children. In practical terms, these perspectives would create a community map of what was perceived to be accessible and effective, and what was perceived to be non-inclusive and judgmental, and where the perspectives converged and diverged from each other. In addition, the researchers made several trips to the community as a way to see, and to put into context, what was described in the interviews.

Structured in-depth interviews were then chosen as the most appropriate method of data collection as it was important to hear about experiences in a person's own words: this was most important in terms of parents. The researchers did not want to privilege particular facilities or activities over others as previous community-based studies have shown that effective interventions or activities targeting marginalised populations are sometimes 'simple' or ones that are undertaken by community members rather than more formally funded (see McKay, 2009). Interviews here allowed for participants to talk about issues that directly affected their interaction with children aged 0-8 years, and acknowledged that these interactions were necessarily diverse. The stories gained from these interviews not only create a more holistic view of how children aged 0-8 years with additional support needs are (and are not) included within one rural community in NSW; these stories also create a more holistic view of how challenges are overcome by those involved in providing care for these

children (whether as parent or service provider), and how these challenges are multifaceted and interwoven.

Sixteen people participated in a structured in-depth interview. However, two of these interviews were conducted with local historians as a way to gain contextual knowledge of the community and so were not included in the analysis proper. The other 14 interviews were conducted within the two broad groups – ten community leaders and service providers (including schools), and four parents of children aged 0-8 years with additional support needs. There were four different interview schedules: one for the Mayor, one for Aboriginal community leaders, one for service providers and school principals, and one for parents (see Appendix 1). While questions differed, the focus on access and inclusion for children aged 0-8 years and their families remained the same.

Consequently, 14 interviews were transcribed and then imported into NVivo11. These were then explored using interpretive thematic analysis. This analysis took a deductive approach whereby the themes were uncovered through reading and coding the transcripts of the interviews. Indeed, the researcher had neither heard nor seen the transcripts of the interviews before starting analysis. In this way, it was felt that there was as little prior knowledge as possible that could potentially colour the findings. There were three stages to this analysis. First, hard-copies of the 14 interviews were read with notes taken in order to gain a global sense of the experiences uncovered through the interviews. Second, the interviews were then coded into broad themes: some corresponded with one or other of the two groups (community leaders and service providers, and the parents of these children), but some corresponded to both groups. These broad themes were then analysed interpretively to uncover finer narratives – how specific issues were spoken about by participants and the nuances of interwoven stories.

It is important to note here that pseudonyms will be used throughout the report, as a way to protect the identities of the participants and to ensure the safe space in which they told their stories initially remains intact when findings are shared. Notwithstanding the aforementioned statement, all participants signed a consent form which indicated that even though pseudonyms and that the interviews would be anonymised insofar as possible, through some statements it may be possible to identify some participants at the local level. There is one exception to this. The Mayor acknowledged that she would not be able to be left anonymous,

given her position, and was in agreement that her name be kept the same. In addition, long quotes will be indented, while shorter quotes will be incorporated into the text with quotation marks. All quotes will be attributed to the participant. Further, while all quotes have been kept verbatim, square brackets have been used when a word has been added or substituted into the quote as explanation; for example, when a participant talks about a specific person, their relationship or role will be added in square brackets beside the name.

Brief Description of the Participants

Community Leaders

Katrina has been the Mayor of Moree since 2008. Simon, David, and Laura are all Aboriginal elders in the community.

School Principals

Patrick and Carrie are the Principal and Deputy Principal, respectively, of the Primary School. Joseph is the Principal of the Independent School. Rosa runs Preschool-1, and Helen teaches at Preschool-2.

Service Providers

Edward and Maria are employed at an Aboriginal Youth Service. Ben runs a not-for-profit, member based youth organisation.

Parents

Olivia has a son with cerebral palsy. Rob is eight years old and uses a wheelchair to mobilise. Sarah has a daughter with Autism Spectrum Disorder and Eliza is seven years old. Sophie has a son with sensory difficulties who is four years old. Becky has a son with autism spectrum disorder and he is seven years old.

Chapter 3: Results and Discussion

As explained in the Methodology, the themes presented in this section came from a deductive analytical approach (Braun & Clarke, 2006), with the aim of exploring issues around accessibility and inclusivity of children in Moree, NSW. The themes interweave together to create a ‘moment in time’ of what the community looks like in terms of these issues through the perspectives of two groups: community leaders and service providers, and parents of children aged 0-8 with additional support needs.

Issue of Perceptions

The negative perception of Moree by those outside the community (particularly people who were described by participants as living in big cities, such as reporters from Sydney) was an issue that appeared in interviews across both groups of participants. However, it was expressed in different ways in terms of impact. Understanding how these perceptions of others are experienced by people living in Moree is important for two reasons. First, understanding how Moree is perceived by others sets the context for why some services and infrastructure may not exist in the community. Second, and arguably a consequence of the first, these perceptions can also taint the views of community members themselves, even if they know the perceptions are only held by outsiders who have either never visited the community, or who have visited with a negative agenda. This taint can have tangible impacts on the ways in which people move through or interact in their community.

There was a sense that some media outlets were only interested in painting a negative picture of Moree. Some community members felt victimised by the press: “we’re a whipping horse for media in Moree and it doesn’t help things at all” (Katrina). This was demonstrated by a story told by Katrina, the Mayor, of a story on Moree that had been published in a major Sydney paper not long before the interview was conducted. The story had been published with one particular image of a disused playground – the interviewer had seen this evocative picture and read the story. As a result, Katrina and the interviewer were able to discuss the disconnect between the image and what was happening in the community in more depth:

...And the playground in which the photograph was shot, they had gone past a heap of perfectly good playgrounds. That was an old disused playground and the grass was

long, waist high.... I had particular contempt for the girl who wrote [the article] because she spent a lot of time with me and at the actual time, that she was here in town, Pius Medical Centre were having an incredibly informative and good two-day session going on...and I said to her, "I can get you in there. I can take you to see". She wasn't interested. She didn't want to go there. She didn't want anything positive. She didn't want to see how communities are helping themselves and I have extreme respect for the Pius Medical Centre. They're terrific. They're fantastic. And it was one of the biggest workshops on drug use and drug effects and drug measures outside of metropolitan area and she didn't want to report on that. And I thought that was bad. (Katrina)

Indeed, another issue seen within this negative experience with the media was the continuing representation of Moree being a community in which the use of drugs, particularly ice, was exceptionally high when "our problem is no worse than anywhere else" (Katrina).

Furthermore, Katrina felt that these negative media portrayals – creating Moree as an icon of dilapidation, poverty, and drug use – tangibly impacted on other positive aspects of the community. Moree is famous for its artesian thermal springs, which are widely advertised, nationally and internationally, for their therapeutic value. The negative stories were released before Easter when tourists were expected during the school holidays. Katrina worried that:

...we will never know and Easter has always been a big time in Moree, because the weather was beautiful. We will never know how many people decided not to come to Moree, that may have been planning their Easter trip and things like that, but decided, "Well, we won't stop over in Moree". And, this is what those people will never factor in.

In this way, Katrina worried that, no matter what services and infrastructure existed in the community, or how inclusive and accessible, the media "don't want a good news story out of Moree". The outside media were perceived to overlook community and individual successes and, as a result, the negative perception of Moree continued and the community continued its battle against these stereotypes. This was an exhausting fight:

You know, there's a lot of very good people that want to make a difference. Every time one of these negative reports comes out, you know, I don't say we take a backwards step, because I just won't take backwards steps, but it puts us... take a few sideways ones. But you think – oh really, here we go again.... people always remember the shit. It's a shame. But, we're used to it. We don't like it, but we're, as a community, we're evolving past it. (Katrina)

Yet, negative perceptions of Moree were not only found in outside media, but local media as well. It seemed as though the outside negativity tainted how Moree was represented in the local newspaper. Becky claimed that her daughters did not want to walk during the day by themselves because they felt the streets might not be safe, although there was no evidence of this. Further, when describing the lack of information about services in the community (see a later section for more details on this), Olivia stated that the local newspapers had no helpful information about what was on in Moree: "There's lots of things that go on here that could fill that paper, they just fill it with bad stuff". In this way, there was a sense that the negative perceptions of Moree tangibly impacted on how parents could locate inclusive and accessible services for their young children.

Services Currently in Moree to Support Children Aged 0-8 Years

As cited by the Mayor, there are 68 services or organisations located in Moree, although it should be acknowledged that not all of them are focussed on children and families. However, out of this seemingly large number, it was uncertain as to how many organisations, and which ones, provided support or ran programs that either specifically targeted, or were accessible for and inclusive of, children aged 0-8 years. There was not only surprise among some of the other participants upon finding out the number of organisations, but there also seemed to be a lack of coherence among all the participants as to which organisations, and which services, were appropriate for children within this age group and specifically for children with additional support needs. One school principal could not name any services located in Moree that would be appropriate for these children. Other participants named services that were arguably more appropriate for older children, for children without additional support needs, or for parents who needed support with other issues. It was also noted by one service provider that different parts of Moree were better-serviced than others: "it seems to be more inclusive if the service is on the west side... or on the north side" (Ben).

Certainly, the responses given by participants when asked about appropriate services did not elicit 68 different responses, nor was there significant overlap in what people listed. However, this also needs to be considered in terms of the myriad and different needs within this group of children – a variety of (interconnected) services will always be needed.

The organisations and services named by the participants ranged from government, non-government, to (seemingly) less formal community groups. It was clear from the interviews that the participants were not sure what services were available or how to access them. Parents talked about having access to services and therapies outside of Moree, or the wait for specialists to visit from larger centres such as Armidale or Sydney.

In this way, access to therapies that were vital to a child's continued development were very much dependent upon whether the specialist continued to visit Moree (and health professionals could and did move in their jobs), or whether the parent had transport to take their child to the appropriate services. Olivia's son Rob was beginning to grow too big for her to easily carry, and she struggled to get him places: "Transport is always an issue for us though.... I have a van that we are going to put a lift in to. It's about \$10,000 so we just can't afford that right now.... I am running out of time, because he is eight and getting heavier". Combined with a wheelchair which did not fold as it was required, Olivia 'made do' with what she had but the difficulties attached to doing everyday activities was clear throughout her interview. This is also demonstrated in a later section. Even when transport was provided for her, such as an Angel Flight for Rob to see a specialist in another hospital, the wheelchair was still problematic: "... I had to take my husband. I can't get [Rob] on and off the plane and I can't get his wheelchair, so I had to buy a little pram then, because his wheelchair doesn't fit onto the plane" (Olivia). As examined in a later section, difficulties with transport could combine with a lack of inclusion to increase a person's social connectedness within the community: "Transport is, I suppose, if we wanted to go out somewhere, there's only one taxi that can take the wheelchair. But we don't go anywhere so it defeats the purpose, doesn't it?" (Olivia).

As a result, children aged 0-8 years with additional support needs appeared to be between services, falling into a gap where services were arguably more presumed than existing, and there was little knowledge between service providers, community leaders, and parents as to

appropriate services. As Olivia stated, in some ways, there seemed to be “nothing that is actually theirs”.

Facilities and Infrastructure

In line with Olivia’s statement, above, there was a narrative from parents and some service providers that some facilities appropriate for children (of any age, let alone the ones under investigation in the study) simply did not exist at all in the community. Olivia spoke about the connection between not knowing what was available in Moree (explored in a later section) and there simply not being activities to do: “I think it just all comes down to that we either don’t know what’s out there or what’s available and there is a lack, a lack of facilities. It’s not being able to go out and do things... there is a huge lack of things to do”. Participants suggested that the community would benefit from:

- a movie theatre – parents talked about driving about an hour and a half to a neighbouring town to see a movie;
- ten-pin bowling – an activity that could be undertaken as a family unit and didn’t involve having to sit still for extended periods of time;
- a sensory gym – mentioned by the mother of a child with Autism Spectrum Disorder as somewhere ‘safe’ for children who were sensitive to sound; and,
- a place a family could have dinner together, and the children had somewhere to play – pubs were problematised in this space.

The above list highlighted the limited choice of what was available for children to do in the community. There was a sense that the only activities available were connected to sport, which may not have appealed to, or be appropriate for, children aged 0-8 years with additional support needs:

I don’t know I guess we have lots of sporting stuff. There is ballet, I guess there are some things. We don’t have a movie theatre, not that [Eliza] would sit in a movie theatre anyway. But in Tamworth they were doing autism screenings. [Eliza] loves 10 pin bowling, we don’t have any fun things, or even like a Play Land. In Tamworth they do – they have this big play centre, all different age appropriate. We only have

sporting things that my kids are not interested in anyway. Not everyone is interested in sports anywhere. It's good to have alternative things. (Sarah)

In this way, it was not enough to point to one sports activity – or any individual activity – and use that as the sole example of inclusivity or accessibility. A lack of choice meant a tangible lack of inclusion here because it created a binding label of what could be done, rather than allowing a child to explore what they might like – and then be able to not like a particular activity without the consequence of then having nothing to do.

Further, the lack of somewhere for dinner was perceived as an added, and somewhat unexpected, difficulty to the lives of these families. In some ways, facilities like a movie theatre were framed more as a luxury – it was uncertain how often a family would go to the cinema. In contrast, being able to go out to dinner was framed as an accessible activity – one that should not involve much planning or expense necessarily. The fact that this activity was difficult, negatively impacted how parents perceived the town – they were isolated in the evenings:

Like there's one place where you can go to dinner and there's a bit of playground equipment that they can play on, but other than that, it's quite challenging to go out with kids around Moree. There's no... I know that they've tried to get ten pin bowling and all that sort of stuff here, but there is not really any activities that you could do, like in the evening with your kids, I feel, that I have knowledge of, anyway. (Sophie)

[The Pub's]² got a bit of a play area and they do a nice meal, but on a Thursday, Friday, like, you've got all the drunks in there. They're all rowdy and that... Straight off, that's a no go for him, so you just can't take him there. So we usually just get him a feed of hot chips and take him down to the river and he's quite happy just sitting on the river, where there's nobody else around.... more of a variety would be really good for him. Not just for him, but for everybody really. (Becky)

Further, it was not just a lack of facilities, but that even the facilities that existed needed to be repaired or replaced. Olivia spoke about the wheelchair accessible swing at a local park. This particular park was not only accessible for Olivia's son in terms of pushing his

² Changed to a generic name to avoid naming a particular establishment

wheelchair safely, but this specific swing was the only potentially accessible play-thing given his quadriplegia. However, the swing had been broken for some time when the interview was undertaken and remained broken when the researchers visited the community several months later:

There's a wheelchair swing at one park, which we did try to go to a couple of times, but both times the swing is not even there or the bits are but they have taken away the actual swing. And I don't know if it's the council, something to do with the council. Then the other one, we've taken him and tried to walk him round with the kids but we can't because it is very unstable. We've just got to be really careful.... He wouldn't be able to push himself not out there. It would be good if there was a bike track or something that we could access for him. (Olivia)

Indeed, with the one accessible park being removed from use, when asked about what the community needed to provide to children aged 0-8 years, Olivia answered: "...even just a sporting ground that you're not going to break your ankle every time you go for a run on it. I think the facilities need a bit of an upgrade as well as one or two new little things. They are never going to be able to keep families here. There is nothing for them to do".

These conversations also highlighted the need beyond 'the medical' in terms of services and facilities for these children and their families: these children had personalities beyond their diagnoses, lives beyond their medical needs. There was a narrative here of what did, and would, make life 'nicer' in the community, whether this was the ability to have dinner with your family, or a working swing for your child when you went to the park. This was even demonstrated when one parent explained why she travelled to another community to shop at Big W as the shops in Moree simply didn't provide her a 'nice' shopping experience:

It's affordability. I know a lot of the stuff you can get here, but the shops are all spaced everywhere and knowing what is in each shop, when you have kids, to go and park somewhere and jump out and go into a shop and find out that they don't have it and then go to the next shop. Like it is just too much, when you know that Big W has it, and it's affordable, that's what you need. (Sophie)

More of these ‘small’ but important experiences will be explored in a later section of this chapter.

Underpinning the narratives from the parents, however, were the narratives told by the community leaders and service providers about the politics around how facilities and infrastructure were implemented and maintained in the community. It appeared that promises of improvement were not always followed through. One of the service providers, Ben, worried that people were becoming disillusioned about stories of positive change, when they were surrounded by such a lack of services:

I suppose the community’s probably heard the story so many times, that people are going to come in, wave the magic wand and change the world but, you know, it’s a hard struggle. And, you know, there’s limited resources for entertainment for the children and limited shopping, limited a lot of things, you know. (Ben)

Here, the argument became one based around the small size of the community – could facilities like a cinema make a profit?

Moree struggles to sustain them sort of activities [cinema and ten-pin bowling].... even with cinema in Narrabri, they run that at a bit of a loss. I think that, basically this is the same line that Moree is looking at too. We haven’t the numbers here and you know to, that’s going to flood a cinema all the time... It’s going to be hard, so it’s going to be a struggle. So, they’re going to be prepared to run at a loss to provide it. (Ben)

While this may have been conjecture – there was no evidence presented to suggest that the Narrabri cinema worked on a loss – there was a definite sense of Moree’s small population contributing to its lack of services. As explored in the literature review, while Moree’s population has only declined by a small percentage, this works out to a noticeable number of people leaving the community – and it was noticed by community members and community leaders. However, it was also argued that while people were moving away, Moree’s population was not calculated correctly to begin with, as the census did not capture everyone who lived there. The Mayor argued that this incorrectly-smaller population negatively

impacted on whether services thought they would be able to make a profit, and that the council was trying to mitigate this disadvantage:

...we haven't got a total correct view of the Census. So much so, that when the last Census came out, that we actually had a couple of people out in the community trying to encourage and work with people to help them fill in their Census, if they found it a bit too arduous.... And, that too, affects the likes of a Best and Less and Big W, and places like that, because they say your population's only like 8, 9 grand, or whatever it is at the moment. (Katrina)

Inclusivity within Kindergarten/Preschools and Schools

Given that the age range under investigation within this study was 0-8 years, kindergartens/preschools and primary schools were discussed by parents and the principals of some of the local (pre)schools. However, perceptions of the inclusivity offered was impacted in two ways: 1) what the (pre)schools were able to offer children aged 0-8 years with additional support needs; and, 2) how principles of inclusivity were practised in the everyday.

Preschools tended to be perceived positively by parents in terms of their accessibility and inclusivity. Certainly, most of the principals were able to list different initiatives that were developed and implemented to ensure all children were able to be cared for and supported within this early educational environment. One program attached to the Primary School was described as “an early intervention class which is an individualised program of learning developed by the teacher” where the provision of “an extra person, a learning support officer in every kindergarten classroom for half a day four days per week...gives children a very good start” (Patrick). In line with the definition of inclusivity explored in the literature review (please refer to the earlier literature review chapter of this report), there was a focus on ensuring that as many children as possible were able to access this program. Indeed, education department policy on area boundaries seemed to be the only limitation to access:

The preschool component though is only for children with disabilities as part of our early intervention program. So all kids are welcomed. All kids who live within our drawing area are welcomed. There are some kids out of our area that get in, but we have a limit on how many can get in, according to departmental policy. (Patrick)

There was a similar focus on ensuring inclusion and appropriate support at the smaller, local Independent School. There were only seven children in one kindergarten class which Joseph, the principal, believed benefited the students in the attention they could receive from their teachers and chaplains:

So the small classes really help. We do do kinder transition program as well so that the children get to meet their teacher and spend time in the class and that sort of thing, which helps that transition. We have chaplains; we have a female chaplain and a male chaplain that come in once a week each. And they spend, both times they will be sitting with the kids, reading stories, playing handball with them, just being involved with them. But they also do see the students one on one. Or they will just be an extra pair of hands in the classroom and they'll be there. (Joseph)

In addition, Preschool-1 ran programs that incorporated other local services, which meant that children with additional support needs were being included in more mainstream programs. Further, these programs were not necessarily only for children with additional support needs but for the rest of the family as well, which again strengthened the practice of inclusiveness. Together, this meant that young children with additional support needs were being exposed to activities, like sport, that they may not have realised were suitable, thereby finding new ways to be included with their peers and within the community:

We provide a service that is inclusive in many ways and one of the most inclusive ways is that we actually go into the early childhood services and preschools and long daycare centres and we actually work with the children within their groups. So it's not separate from the other children, the children actually join into the activities... [and] so their whole family can join in and that's working really, really well. And the families are actually saying after they have used us, that they have actually joined sporting groups and that they are feeling really comfortable about that. And that they know how to support their children in that environment. The local sporting groups have embraced those families. So we can't really do much more than that. (Rosa)

Further, Preschool-1 recognised the importance of planning for the future when educating young children with additional support needs. They made two plans a year, but this also

depended on the needs of the child and what the family wanted in terms of this type of support. As will be examined later, this holistic way of perceiving a child and their development was not always practised in the school environment. Here, Rosa recognised that collaborative planning between the preschool, family, and child (as much as they were able to be involved) led to more appropriate and effective support and educational experiences within these formative years:

We do an individual education plan for each child and we have meetings...that include the parents and any service providers that the parents would like to be involved at that meeting. And we sit down and discuss how that little person is going, what their needs are, what their interests are, because we have to bring that in. Mainly because it is no good working with little person if you don't connect. So that is actually what we do. Then everybody is on the same playing field. Then we actually do the meeting, we make our plan up for what we are going to do but in that meeting we actually allocate, this is the goals of the parents, these are their concerns - the priorities and this is the outcome. OK, who is going to look after this, this and this? So that everybody seems to understand, OK, this is my part in this whole plan and then we come back again at a later date to check and see how that is going. (Rosa)

This practice of inclusion was arguably possible within this preschool due to the high level of teacher training afforded to the staff. Rosa argued that this training – and strong links to other services in the community – made Preschool-1 successful in supporting young children with additional support needs, and their families:

We are all early childhood trained, I am actually infants, primary trained and have done a parents as teachers program as well. So that it is dealing with families with little ones 0 to 5, so that is really our background. We actually access therapists for our children as well. We link our families with therapists if we can get them locally, we will link them locally. But if we can't, we have worked really hard at accessing therapists from other towns to come in and visit Moree. So our families aren't travelling. We actually have a lovely occupational therapist who lives out in one of our outreach areas and she does our outreach children for us and she goes to visit them. (Rosa)

Helen, from Preschool-2, also gave practical examples of how her preschool was made accessible for children with additional support needs. Similar to Preschool-1, Preschool-2 became a one-stop-shop for children to have several of their health needs met. Given the difficulty in accessing health services in Moree, as explained by parents earlier in this chapter, access to these services could make a significant difference to the health of children with additional support needs, who may experience a variety of health challenges, in terms of prevention and maintenance:

We also do a bus service so parents who don't have cars are able to get their kids to preschool; we pick them up and drop them off. We do have speech, hearing – all those tested here as well as psychologist comes here. We have speech pathologists come in, while they are at the preschool they will get all this.... And our hearing and eyesight tests are done by the clinic next door, so they come over here and access the kids. We do dental visits – we take the kids over there to the dental, little groups at a time. If there is any work that needs to be done – a letter is sent back with us and that is given out to the parents. (Helen)

As a result of the way in which many preschools were both embedded within the community and focused on children's individual needs and progress, they were generally positively perceived throughout the community. While the waiting list meant that some preschools were difficult to get into at times, Patrick argued that there were strong links between the preschools and the local primary schools:

I think by and large the preschools do a very good job. I know there are issues around waiting lists and whatever. I don't know how that compares with other areas. But certainly they offer some really good programs. They communicate with us around children when it comes transition to school time. They participate in our transition program.

It should be noted that only the principals mentioned waiting lists – this was not brought up by the parents, which suggests that not all families struggle with admission.

This positive perception of how preschools worked with children's needs was affirmed by Sophie, who worried about the use of chemicals in spaces outside her home and how they

negatively impacted on her son. His allergies were a sensitive issue for Sophie and she was passionate throughout her narrative about finding more natural and holistic solutions for them. For Sophie, an inclusive preschool needed to not only be aware of her son's allergies and sensitivities but they also needed to find solutions that were not bound to simply excluding her son from the activity. Here, Sophie found one local preschool accessible, inclusive, and supportive:

He goes one day, at the moment, out at [the preschool] and they are unreal. They actually have changed the way they make their playdoh and the soap they wash his hands with. I'm not sure about cleaning the environment, but they do lots of play outside and they don't let him go near the shaving cream sensory play. They'll bring other things in instead that is appropriate for him and includes him in the whole room. And I found, like a couple of the teachers there are very open minded to it and really respectful and really loathe... The stuff that I am talking about is going to benefit all the kids anyway, by getting the chemicals out of the environment and their play. So, I have been happy with that playschool.

However, not all schools seemed to practise inclusivity effectively. Becky found that her son "did two years of early intervention, he went really well". However, his first year of school did not seem to be as successful in terms of development as there was a lack of communication between the school and the parents: "Kindy, he went downhill that much, he couldn't read, couldn't write. Well, now, he's reading. He's writing. He's picked up a lot. But, the school does not actually tell you if you need a bit more support, you could go to here, or here, or here" (Becky). In this way, Rosa's commitment to twice-yearly, individualised plans for the students at Preschool-1 demonstrate the importance of regular and meaningful dialogues between the schools and parents when determining how best to support young children with additional support needs in their formative years.

Compared to preschools, there were more varied perceptions around how and whether primary schools included children with additional support needs in a way that was appropriate and effective. It should be noted here that, in line with the focus on children aged 0-8 years, this analysis is only concerned with preschool, kindergarten, and Years 1-3 of primary school. First, the support offered to a child when transitioning from preschool to primary school was important:

Children, who come from kindergarten to Year 2, will have adjustments made to their program and those adjustments could be as simple as participating in a targeted reading group. It might be that they have a learning support officer helping them and supporting them to do other things in the classroom. (Patrick)

In this way, there was the potential for a more seamless move from one year of schooling to the next, which allowed for a child with additional support needs to feel more secure.

In addition, and similar to Preschool-1, the Primary School focused on creating individual plans in collaboration with parents for a child with additional support needs. This plan would involve understanding the personality of the specific child, the nature of their disability and how it affected their ability to participate in different school classes, and what support was needed to best support the child and their educational experience. Consequently, there were several options available for the child:

...it's about planning, it's about knowing the child's ability, knowing who the child is, knowing what they can do and what they can't do and it's about working with the parents to plan for what they want for their child. So they have a range of options and if we took an example of a child who's in kindergarten with a disability whether it's a diagnosed disability or it's a disability which has manifested itself such as poor reading or something, we would plan with the parent. We would offer a range of options from in class support with a learning assistance teacher or a school learning support officer. We'd have a targeted learning program which would say these are the goals for this child. For some children we'd sit down and say well, and the parents may agree that the child's better suited in a support class which would have a smaller number of students and higher levels of support from a teacher and a school learning support officer. So the way we cater for kids is based on their needs. (Patrick)

In this way, children with additional support needs had the opportunity to attend mainstream classes in kindergarten and in Years 1-3 if it was appropriate for them – their disability did not automatically place them within a restricted or withdrawal program. The Primary School was able to include children with a range of additional support needs in multiple ways. Patrick detailed that there were “quite a number” of children with varying

physical, intellectual, and behavioural difficulties who were “in regular classes, they have adjustments made to their program and they’re supported”. In addition, the Primary School had four types of support classes, depending on severity of disability, the age of the child, and the level of support required. However, a child’s inclusion in a particular class – whether mainstream or support – was not static; children could move between classes depending on their ability:

So if a child is doing very well, they may well go back into the kindergarten/ year1 /year 2 class. Depending on what their needs are they will do that. They may go back for specific things too... if their strength is around mathematics, they might go do mathematics in a regular class. It could be art, it could be whatever their strengths are. (Patrick)

Further, while educational classes may have been separated, time outside of class was fully inclusive. All children were able to play together at lunchtime and during other breaks, and everyone participated in the regular assembly: “they participate at all levels of our school, it’s normal” (Patrick).

At the Independent School, there was similar flexibility in terms of how a child with additional support needs could be included in class – inclusion was just practised differently given the smaller class sizes. Joseph gave an example of how working collaboratively with the parents of a child with additional support needs allowed for successful transition into school:

We did partial attendance and that really worked well. So for the first two or three weeks of school, he was on half days and that helped hugely and slowly but surely increased that.... his parents were also running a program at home. So they were also happy to keep that program up and running and not tire him out completely with full days at school. And that transition worked very well. That was a very good move....

In addition, Joseph also argued that small class sizes assisted in successful inclusion of children with additional support needs – none of the classes at his school appeared to exceed 19 children. At the Independent School, Years 1 and 2 had been made into a composite class (where two grades share a classroom and a teacher. Joseph believed “having a composite

class gives us that ability to either stretch children who are moving ahead or if there is a Year 2 child who has missed out on some building blocks along the way to say okay you know, go back and gives us that flexibility there”. Here, there was also acknowledgement that year of schooling did not necessarily always dictate or demonstrate ability – children whose ability was beyond the grade considered age-appropriate also needed to be supported in their educational journey, along with children who had additional support needs.

However, both Patrick and Joseph spoke about their withdrawal programs as well. These programs were considered necessary when children needed focused attention on a particular skill that could not be delivered similarly in a mainstream class. The main withdrawal programs at the Primary School were Reading Recovery and speech classes as they both required a quieter space and focused attention. Patrick argued that other programs could be incorporated into the everyday of a mainstream classroom given their individual and collaborative learning plans made for each child: “Other programs are done in class, essentially as a school we can identify every child who has a particular learning need and we can identify the adjustments that are made for that child. We have a good understanding of who is who and what they need and we make that support happen”.

Similarly, withdrawal programs were used sparingly at the Independent School, dependent on what the children needed and the availability of the teacher. The focus was always on inclusion within mainstream classrooms as much as possible and as long as appropriate:

...it is a very short period of time. It translates to two days a week really. [The teacher] sometimes does half days so its spreads out. But the reality is its two days a week. That’s how we try and also just from a practical point of view in class, it’s how we structure our group work, all that sort of thing. Whether it’s mixed ability groups for certain things or streams for other things. Also just trying to do as much particularly around maths and that sort of thing as much hands on work in the primary school as possible. So it’s helping them to learn in a concrete way. (Joseph)

In this way, the schools’ philosophy around the inclusion of children aged 0-8 years with additional support needs aligns with the positive philosophies explored in the literature review.

However, some parents with school-aged children did not believe that some schools practised inclusivity in the ways they espoused it. Olivia had experienced a particularly difficult year when her son Rob attended school. She found that Rob experienced neglect in very practical ways, one of which was the fact that he needed assistance in being taken to the toilet and having his nappy changed. She had been told that the school did not,

have time to toilet him four times a day, we'll change his nappy twice. OK, you are going to tell me that a child that can walk and talk will come in here, far be it she has a nappy on, a pull up, but you will take her to that toilet and you will change her. You will pop her on the toilet, let her do her, if she's done an accident you will change her anyway so what's the difference? It's huge... I just feel like he is too hard work for them.

Olivia had not accepted this argument and had sought the support of a therapist in putting her arguments for Rob's wellbeing in front of the school, but this had effected little change: "They've got a huge bathroom but they can't do transfers because there is not enough room. That's why they can't toilet him. They will just change his bottom". As a result, some of Rob's most basic needs were not met by the school, and this lack of toileting would arguably impact on how other children in the school perceived and interacted with him.

Olivia listed further health issues – "little things" – Rob had experienced in attending a school that did not always understand his needs. A lack of air-conditioning (whilst waiting for the system to be repaired) meant his class became over-heated, and there was little knowledge around Rob's sensitive skin or food intolerances, which led to rashes and bloating, respectively. Olivia's experiences were reflected in Sophie's fears around her son attending school, especially after such an inclusive and supportive preschool: "How's he going to go with it, like is he going to come home pinging from either the chemicals in the environment or not being able to sit in a room with a fluorescent light and stuff like that".

Further, there was a sense that the accessibility and inclusivity of a class depended on the effort made by the individual teachers. Olivia worried that the school didn't "modify anything for special needs children. They just – this is how we teach you, if you can't do it, you can't do it". She gave an example of a board where numbers could be flicked until the correct answer was reached which required a child to have dexterity with their fingers. This process

was not changed for Rob despite the fact that he couldn't move the numbers with his fingers and thus became disempowered in this learning task as other children had to answer for him. This lack of flexibility in making a task accessible was exacerbated by the disconnect between the aims parents had for their children within this formative education experience and the aims held by the school. Rob's physical difficulties meant that he would often burp during class. Olivia was concerned that "one of [the school's] main goals to learn for the year is for him to say "pardon". I was like that child can count to 10, teach him his alphabet, teach him his counting, he grunts when he says pardon.... And that was pretty much all they wanted him to do". As the focus of her child's education seemed to crystallise on a social pleasantry, as opposed to extending his abilities, Olivia made a point of examining how Rob was included in the classroom and the learning activities of the other children:

I've caught them a few times they just sit him in his standing frame and sit him in front of a touch board, the smart board, and he touches it and makes it sing and carry on. And that's great for down time but the other kids are working non-stop and he's there touching the board and making it sing. Couldn't you get him to do something similar to what they're doing? You know make it a classroom, not make it 'oh well [Rob], while I am teaching the class you can go over and do something and stay out of my hair'. It's because he is the quietest one in the class, he doesn't complain, he just, he'll find something he likes to do, he's good there for half an hour.

In this way, it seems that Rob's school did not practise inclusivity as defined by the studies explored in the literature review (see an earlier chapter in this report). Activities within a classroom were not flexible enough to adapt to Rob's needs, and he was not given the opportunity to explore how much he could participate in the mainstream classroom. As a result, Rob could not add to his abilities, which negatively impacted on his future potential to enter a mainstream classroom at school, as he was not exposed to enough experienced and appropriate teaching practice. Rob's negative educational experience was something that Sophie worried about her son also enduring. Here, Sophie acknowledged that her concern around her son being in the 'wrong' school meant that she was spending a significant amount of time searching for the 'right' one:

Is he going to come home and not be learning anything five days of that or will I maybe fluke a teacher that can work with him and help him with bouncing a ball or

whatever it is to keep him focussed or is it going to be the luck of the draw. That's why I am kind of like putting it off for another year and looking at the smaller schools around as well.

The language around 'luck' in terms of finding a supportive a teacher and school was found within the parents' narratives (and also in terms of finding appropriate services and support within the local community, as explored in an earlier section of this chapter). However, the concerns around 'luck' were similarly replicated in the narratives of the teachers (and the organisations, as explored in a later section of this chapter) in terms of funding and the limitations and prescriptions put on funding arrangements, preschools, and schools may have arguably all had good intentions in terms of practising inclusivity for children aged 0-8 years with additional support needs, but a lack of funding (or the restrictions around it) may have hindered the practice.

Patrick worried about the negative impact waiting lists for preschools could have on children accessing suitable educational support during early childhood. However, while waiting lists were not commonly mentioned in the narratives of the interviews, the restrictions around funding were in terms of which children could be included within a school or service, and how. The funding body for Preschool-1 had "definite guidelines on how we actually utilise their money. There is a criteria of the children that can access our service, a diagnosed condition, significant developmental delay that has been identified, or children at risk, they are the ones we mainly focus on" (Rosa). However, Preschool-1's funding body encouraged that the preschool be as community-embedded as possible so, while restrictions existed, Preschool-1's programs were supporting

families [to] realise they do have a voice and that they can make cases for their children. They just need to feel that they have the power within them and that they have that choice and that's what we are here for to help them and to point them in the right direction. It is just like taking the layers of an onion. (Rosa)

However, funding was not always available, and – as will be explored in a later section of this chapter – this lack tangibly impacted what support could be practically offered, as well as how appropriately and effectively it could be delivered. Joseph, the principal of the Independent School, talked about the need for more teacher training around providing an

inclusive and accessible classroom environment. Without adequate training, young teachers especially could feel out of their depth teaching students with additional support needs:

A lot of the teachers feel so under pressure because your heart is to do the very best for the students. But at times you just feel at a loss as to help them the best way. So you are always second guessing yourself you are trying to do the best but you are sitting there going I am doing my best. I really don't know if I am doing my best. You know I can see yes there are improvements but could I be doing more. There is this tension there for the teacher the whole time, wondering whether they are actually doing their best for this child. And it puts a lot of stress on the teachers. (Joseph)

In this way, good intentions were not enough and the stress experienced by teachers in trying to offer the best support possible could lead to burn out and disillusionment, particularly in a more remote community with limited access to services. Joseph listed different training programs he had accessed for his staff, including one specifically around autism. While the costs of some courses were reduced for the teachers, depending on which organisation was running it, “a lot of them do come with a price tag. I'd said your cheapest courses are generally \$300 but then we have still got to get to Sydney. It's the flights and the time out of school and the relief teachers so it all adds up. So yes it is pretty expensive” (Joseph). Sometimes, this could mean that training may be limited to particular staff, or to the more affordable and local courses.

Perceptions and Experiences of Access and Inclusion Among the Aboriginal Community

The negative perceptions of Moree, particularly in the media, were argued to impact on Moree's ability to attract new business and residents, and keep the older ones from leaving (please refer to the earlier section of this report). However, one recent news report in the Sydney Morning Herald was deemed particularly hurtful to young Aboriginal people (see Olding, 2014). The Mayor related that “a lot of my Aboriginal friends and associates were shattered over that report, because they said, ‘You know, it's so unfair. Why, why do they hate us so much?’ And what these stupid... she was a child... She was so young, that girl. I was horrified.” There was a sense of being knocked back by those outside the town even when people within the community were striving forward. However, the Mayor was

supported by one of the study participants: "... I think for the first time in Moree history we have a Mayor who's prepared to go out on a limb, and Katrina speaks her mind, she speaks her mind and that's one of the things I admire about her..." (David).

However, the Aboriginal elders who participated in this study did not mention the Sydney Morning Herald Report. Instead, they spoke about their own lived experiences of access and inclusion within the Moree community, and how they saw their children and grandchildren being able to access, and be included in, different services and facilities. This was especially important in terms of healthcare provision, as one of the elders had a young grandchild with additional support needs.

There was a sense of increased inclusion within the elders' narratives from when they were growing up in the area to how they perceived the community currently. David remembered the segregation that had occurred in Moree when he was growing up (and that had occurred throughout Australia prior to the 1967 Referendum). David saw how the culture within the town had become more inclusive, but his perceptions were also necessarily coloured by his experiences as a child. He had lived through this cultural shift, which meant he carried some difficult memories of racism and discrimination:

I think now that I'm a bit older I get more involved now - I feel included, but growing up as a kid living on the mission I didn't feel I belong; we were made to feel unwelcome when we came to town, in the picture show we had a section where we had to sit, had one shop that we could go into it wasn't really, you know you didn't made to feel welcome to come into town, that's why we stayed out on the mission, but now since I got myself educated and got myself involved with the different organisation and I find I'm more accepted in the white community, and yes we still got a long way to go in town in Moree, but it really is 95 - 100% better for kids growing now then when I was growing up, so there has been a lot of changes but there's still a long way to go. (David)

However, another elder perceived inclusion in a more practical light. Laura spoke about inclusion in terms of how she was able to interact in her everyday life, compared to others with a different life experience to hers. For Laura, inclusion was grounded in the communication with others afforded by employment and the internet:

My personal answer to that would be that I'm still working and I have access to the internet and email and I'm part of the daily events that happen in Moree where people who don't work or have the internet or have part of an ongoing communication relating to issues there left out they seem to get the information a couple of days later, and that could involve them at that point, so I feel because that they're not in the loop with the communication; they feel left out that starts the negative communication, why wasn't I told, like yesterday when it happened when I don't have access to the internet or email I think by working it keeps you really up to date with what's happening in the community. (Laura)

Even within this subjectivity, Laura's response still fits to the original definition used in the beginning of this report.

However, it appeared that access and inclusivity differed between adults and children, and those who had additional support needs. Simon further differentiated between age groups (within the 0-8 years range) in terms of ease of inclusion where he thought children aged 4-8 years old would be more able to be included within different activities, whereas children younger than this could not be so easily included in broader community activities. Laura argued that effective inclusion of young children in the community meant that a service or organisation had to also include the (great)grandparents in the sharing of information. Here, services needed to look beyond the parents and acknowledge a wider community of childcare "as a lot of the elders now are caring for their grandchildren and great grandchildren, so I think a follow up phone call [to the grandparents] is needed to say 'did you receive the message?' ... [as] the kid could have been referred to a speech therapist or something." (Laura)

Yet, while Simon felt included in the community, he worried about two of his grandchildren, both of whom had additional support needs requiring stays in a Sydney hospital: "...they have special needs and they go to Sydney to see the doctor.... they go to [a Sydney Hospital] yeah, but we're very close to them and we monitor them, take very good care on how we handle them, and play with them". Indeed, as with the other parents, the time and costs connected to travel was recognised to negatively impact access to appropriate and effective healthcare: "It's very difficult you know very difficult not only for the parents but

us, even as Elders, you know if we have to go to Tamworth for our doctors we have to access travel and accommodation if we have to stay overnight it's a big thing, a big thing" (Simon). David worried that, without adequate public transport, "some mornings you see mum and dad and five or six little kids walking across town in the morning in the cold". Further, and in line with Olivia's narrative, Simon and Laura both decried the lack of wheelchair accessibility to some basic services in the town.

Yet even with these regular trips to Sydney, similar to the experiences of other parents within this study, Simon felt that the local services did not advertise themselves successfully. He felt that he only discovered services by walking down the main street:

...some of them do some of them there great, then other people, you walk up the street and say 'Hello, when's this been open? I never heard this why hasn't this been put in the papers or something? You know, I go half way there I'll say yes and I say no I don't think they're selling themselves really out there. (Simon)

However, also similarly to the other parents, Simon had found services that worked for his grandchildren: "I know I can speak on behalf of [the Disability service provider], here I can really say they there fantastic especially with disabilities young children 0-8 with disabilities". Simon also found the Aboriginal Medical Centre to be inclusive and accessible. Further, David positively mentioned Preschool-2 as his grandson had previously attended there.

Yet, there could also be issues with accessing visits to the GP, again similar to other parents. David worried that children, especially babies, were vulnerable to missing out on healthcare if their parents were not able to communicate with the GP's office, a potentially difficult path to navigate when a parent is stressed and vulnerable due to their baby's illness. David gave the example of his own daughter who had initially been told there were no appointments until the following day when she became worried about her sick baby. David called the GP again to tell them the age of the baby (six months) and demand an appointment for such a young child, and his granddaughter was seen straight away: "we wouldn't have got that a year ago, we would have been told to wait your turn, but now that things are different were been more forceful because we know what our rights are". His daughter had not disclosed the age of her child, which was an important factor for the GP's receptionist to know when making an emergency booking. However, given the stress David's daughter was

under, this is understandable and speaks to the issues around effective communication between doctors and patients, and the vulnerability of patients (such as children) who cannot speak for themselves. Similarly, Laura also argued that communication was vital in ensuring effective and appropriate access and inclusion. This communication needed to start at the family level and then spread throughout the community – if families communicated well between themselves, they would thereby be more able to communicate well with others outside their family.

However, when the focus was on children, there was a necessary and complementary focus on their parents, as children cannot advocate for themselves. Until they are recognised as adults themselves, their parents (or grandparents or guardians) are their legal voice in terms of access and inclusion to many health-related services. In this way, two of the elders argued strongly for parents to also be supported, which was in-line with some of the local organisations (see the work of Edward and Maria discussed later). Simon argued that children could easily fall into the gaps between services and support when their parents were struggling with substance abuse issues that he considered to be a significant issue in the community as a whole:

... the biggest issue is drugs and alcohol in families and you got kids that suffer, under this sort of thing out there.... I think [the parents] just don't care, they only think about themselves first, not the kids, the little kids come last, mainly. When they get the cheque pension, pension, child endowment, they don't go and get clothes and all that, they go and get alcohol, and all those little kids get left behind. I feel sorry for them, I really do. I think the government has let them down somehow. (Simon)

While Laura agreed that “parents have to take responsibility where they failed and admit that they need help and ask for help”, she also cautioned against taking a negative presumption against parents who struggled. They needed to be supported as much as their children, and such support needed to be appropriate and targeted, with the needs of the parents seen as interwoven with the needs of the children.

Experiences of Social Isolation

Parents were significantly impacted in terms of accessing services depending upon the reactions of others. These impacts were felt across a range of activities, some as simple as simply going grocery shopping or having a cup of coffee at a local café. Becky and Sarah spoke about their discomfort with how others reacted to their child having a tantrum. Here, their child's difficulty with communication meant that they were unable to easily convey what was distressing and "...you've just got to take him home, because he just keeps going and everybody's staring at you... You're just not welcome" (Becky). Sarah spoke about people making negative comments around her parenting when her daughter became distressed:

It's quite hard because I feel like I need to protect her and it really stresses me out... I have had people say – if that was my child I would do this... I don't know if that is just my interpretation of things, but sometime I feel that is it difficult because people judge."

As a result, they found going out tainted by stress, which impacted on the way they experienced everyday life. This was also experienced by a mother of a son with severe cerebral palsy who used a wheelchair for mobility. Going out not only meant maneuvering a wheelchair but also her two other children. Olivia found people either offered help or ignored her:

... You know some people are really really nice and helpful and I actually went out to lunch with a friend the other day and I had taken the three of my kids. And the other two got up there and there's just two little steps. And there was a whole heap of people out the front of the pub. It was in a motel thing, and they all watched me struggle with him up the stairs and I just thought, wow, nobody even offered to help. You know that sort of thing. But then, in saying that, lots of people do help too. Lots of people have offered to push trollies around and things for me but. (Olivia)

Here too, the negative experiences of people not helping meant that Olivia found leaving the house a relatively stressful experience.

Further, while service providers spoke about the difference services and activities provided in the communities, parents' narratives were bound to an uncertainty that their child would be

easily included. There was a consistent sense that parents had to wait and see whether an activity would be accessible for their child. They were not immediately included. Eliza's mother wanted her to start ballet; however, this was abandoned after talking with the ballet teacher.

...there are not a lot of sporting or social events available that are appropriate for [Eliza] and her needs. Like I want her to start ballet this year, they were like, bring her along and see how she goes but we do have to stick to a curriculum maybe we can get someone to do a one on one with her. I just feel everywhere we go everyone is going – she can never fit in that box and I know they are probably include her as best they can but I always feel there is an issue, because she is different. Just come and see how she will go but it's not definite she can come. It's always that kind of an answer."

Even those services that targeted parents of children with additional support needs were not always appropriate. It's important to note that the experiences of parents were not universal – they were entirely dependent on the needs of their child. This further deepened parents' uncertainty around whether it was even worth the hassle of leaving the house when that also involved opening themselves up to the reactions of others. Olivia spoke about attending one mother's group which she had been told would be appropriate and finding a very different experience:

You can go into a mother's group for instance and they are all one certain type of mother. I've been to a mother's group here where, a morning tea here, where they've all discussed how autistic each other's children are and it's like 'but it's not like your poor [Rob]'. Because they could see I couldn't have the same discussions about physio or OT, because my son's too far gone. And that's the sort of thing too, so there's not a lot, there's not a lot of I don't know, inclusion... I have found my little box and that is where I am going to stay, anybody that is different and you don't fit. So I have just learnt to make myself fit and it's getting there. Before they know it, I'm there.

In this way, feeling included was not necessarily an easy process. Olivia felt she had to actively make herself included in groups, or within the community, because otherwise she would never go anywhere: "I've had to force myself yeah, because I've done a year where

probably didn't leave the house. There's probably a handful of times that I left the house. You know child, baby, wheelchair, oxygen tank, let's go".

Further, Sarah and Olivia had both experienced inappropriate comments and behaviours from service providers and schools – the people who were meant to provide safe spaces for these children (and their parents). One service provider had called Sarah's autistic daughter "ignorant" in reaction to her ability to recognise and greet people:

I thought you have three kids of your own and they are typically developing and what works for them and what works with a child with a disability especially an intellectual disability are very very different. I think if they don't know those things and they are struggling with that, it is the organisation's responsibility to up-skill those workers.

(Sarah)

However, Olivia's experience with the school her son attended demonstrated that a lack of training and understanding of a child's specific needs could lead to illness. What she described as "little things" (an indication of what Olivia described as "making do") appeared to be quite serious reactions, especially if occurring regularly:

And little things like he will come home in summer overheated because they didn't get their air conditioning fixed. So 40 something degrees heat they've got special needs children in there... I get a phone call the other day, his ears are red, he's got a rash on his back, well is he fine otherwise, yes, well it's just his sensitive skin. Oh he's got a runny nose, can you come and get him. His stomach looks a bit bloated, he's burping a lot. It's just ridiculous.

While school was meant to include Rob, Olivia felt "like he is too hard work for them". This did not make her feel confident that she could leave her son in their care.

However, apart from Rob's physical reactions, these interactions were all grounded between parent and service provider or community member. However, Sarah acknowledged the potential disconnect between the lack of inclusion and accessibility they felt with what their children felt: "You also want her to go somewhere she feels welcome but that can be difficult. Because from [Eliza's] point of view she doesn't really get it – she is happy. I think

it's maybe my just wanting to protect her. It's natural as her mum". Important to note here is the continuing lack of voice given to children themselves. We simply do not know how they feel within their environment, and there is arguably a continuing lack of voice as they grow into adulthood.

Awareness in the Community of Service Providers

While there are 68 services and organisations in Moree, none of the parents felt that they had any sense of what the organisations did – and whether they provided services that may have been suitable for their children – until they proactively went looking: “A lot of it is not in your face unless you go searching for it, I think” (Sophie). Here, the issue was not the lack of organisations per se, but their lack of advertising and communication in the community. As Sarah stated: “I feel like lots of people don't know where to turn.”

Here, the lack of communication began for some parents at diagnosis where they felt they were given no direction as to how to best support their child and who could help them: “See, he was diagnosed with autism at four, a bit over four, and we were a year, year and a half, before we knew anything about the supports, disability supports, in the town” (Becky). Even though they are often a first point of access into the healthcare system, parents did not consider GPs to be knowledgeable sources of information about sources of support in the community: “...unfortunately, I think that GPs are very, very busy and they aren't an all-knowing source. And, yeah, so, even, yeah, I don't think they even know what services are around Moree as well as other people as well” (Sophie).

This disconnect in information meant that parents tended to seek advice from other parents of children with additional support needs. These other parents had either gone through, or were currently in, the health system and so were often the ones pointing other parents either with new diagnoses or newly-arrived in the community to the types of support they used. Olivia had found this help invaluable: “I can never find anything. I actually had to go to school and ask the other mums where they send their kids... You have to really search or know what you are searching for”. However, information could also be found out through pure chance and luck. Becky had found the Disability Service Provider to be a tremendous support for her child and family. However, she only found out about them by accident at a school event for another of her children:

The school was having a turnout, a little sort of a dinner thing for one of my daughters and... it was run through [a Non-Government Agency]. Only for us going up there speaking to them, they referred us to [the Disability Service Provider]. Otherwise, we still, 12 months ago, we still wouldn't know...

The hit-and-miss nature of being lucky enough to find out about a service meant parents also spoke about missing out on some activities due to misunderstandings around their appropriateness. They simply could not ask each of the 68 services and organisations, whether they would be able to appropriately include their child. For example, Olivia had missed out on attending a parents group because she presumed it was only for Aboriginal mothers. She had also missed out on the chance to take her children to [a Music Group], a music group specifically targeting young children which can be both accessible and inclusive of children with additional support needs depending on its location and organiser: "...I didn't know that was around until now he's started school and he can't go. And lots of those sort of things" (Olivia).

However, it should also be noted that seeking advice from peers was not fool-proof. As with the appropriateness of parents groups (see Olivia's experience in a earlier section), the suitability of the advice depended on the experiences and needs of the child, as well as the values and expectations of the parent: "I guess it's making sure that you're asking a person that has similar expectations or values as you, because you could ask the person next to you and they think they're horrendous, but you could go and really get a lot from it" (Sophie). Here, Sophie was more likely to seek support from holistic services, an approach not taken by every parent. However, Sophie was the only parent who effusively felt that she and her family were included in the community. These feelings of inclusivity through recognition meant that she appeared to be the most confident in actively asking questions of others and seeking out different local events:

Any events that I go to I feel like we, you know, you have familiar faces there. So people are saying 'Hello', 'How are you?', joining you in activities. I guess, for me, like I'm confident seeing familiar faces, and going up and asking them what is happening, and if there is anything happening that I don't know about, going and working out what's going on at events and stuff like that. (Sophie)

However, Sophie also recognised the privilege in these feelings of inclusion and what they allowed her in terms of service support for her child: "...I wonder if you're socially isolated and you're having issues with your children and not chatting with the right person, you wouldn't find out about those services".

When linked to the difficulties attached to simply going out, as explored in an earlier section, this lack of knowledge around what existed, and whether it was suitable, meant that some parents simply found accessing services exceedingly tricky to navigate. It was not simply that parents didn't know where to go for support, and that they had to proactively ask for it, but that they didn't know what support – and at what stages – they needed. Sarah spoke specifically about funding she had received after Eliza's autism diagnosis. This was the FAHCSIA-Helping Children with Autism Package funding, which amounts to \$6000 per financial year, for two years, until the child turns seven years of age. There is also an additional \$2000 allowed for children who live in regional and remote communities. While perceived to be a significant sum of money, Sarah felt that the lack of communication by her GP and other service providers meant that this funding was not always as useful as could be, that parents were still in the dark about the most appropriate way to spend the money to best target their child's specific needs. It was not enough to simply give funding and make parents have to search for support – support needed to be offered from the first diagnosis:

...I think it would be useful when you get a diagnosis – not to just go – your child has a lifelong disability – here's your early intervention funding and you go and navigate all these different things and you work out how you are going to stretch that money out and go on your merry way. It is very hard to navigate that – it is confusing and overwhelming. A lot of families just go – I've seen families that don't even use it because they don't know how to use it. Alternatively they've been told you really need this so they spend all their money on it and then all their money's gone... There are so many different things going on but it's all very confusing and sometimes you don't hear about things. (Sarah)

Sarah suggested that there needed to be some sort of agency that acted as a buffer between the funding and services and guided parents through the maze of discovering what was needed and what was not. Sarah thought one organisation may have recently provided this role in

Moree but she was unsure as what this organisation actually did. Again, there was a sense of a lack of communication between the service providers and parents.

Olivia argued that she couldn't always ask for help because "I don't know what I am looking for, I don't know what I need, I don't know what I am asking for. Until I see either somebody else have something similar or somebody says to me you know you could do that so much easier". As a result, she was more likely to stop asking for help and instead trusted her judgment and made do (an idea that occurred throughout Olivia's story):

We are probably more of the people who just make do, if we can't figure it out we will just do something. Where we couldn't get a wheelchair on the plane instead of forking our \$2000 for or asking someone we bought the pram. We need a transport system but we will get there. It's not urgent. (Olivia)

However, a lack of communication and the subsequent difficulties in asking for help and knowing what to ask for, also meant that some families simply missed out on accessing appropriate and effective care: "...I think, some kids do just go without and don't get as good a care as what you could get in a big city with all those resources around" (Sophie). This is a vital gap to fill as foundational steps in a child's future wellness and wellbeing are arguably made during this age range.

Impacts of Funding Issues on the Provision of Services

Issues around the affordability of teacher training – and the limitations they could place on the provision of inclusive education in schools – have been explored in an earlier section of this chapter. Parents' experiences of a lack of awareness of services were also explored in the previous section. However, what the parents of children aged 0-8 years with additional support needs perceived as a lack of communication from services as to what they provided, was at times the result of a lack of communication and coordination between the services, partly due to the nature of competitive funding (as will be seen in the following paragraph).

None of the service providers who participated in the study held secure funding – all of them relied on governmental and competitive funding to continue which is often limited to a maximum of three-year blocks. Consequently, issues around funding and communication

impacted the experiences of service providers in two ways; first, in the coordination between services; and, second, around the ability to provide services in a consistent sense.

As discussed in a previous section, 68 separate services and organisations were said to exist in Moree. However, while many worked well together (see the earlier example of Preschool-1), there was also a sense that some services did not communicate well with each other due to the competitive nature of some funding. There was, at times, a sense that if ideas were shared, they could also be stolen, and that if one service was funded, another would not be. This either/or narrative constrained some service providers in trusting that they could collaborate together within a safe space – which consequently impacted on how they communicated to community members. One service provider spoke about some organisations being awarded funding for a specific population that they were unable to appropriately provide services for:

A lot of times, those organisations, they'll come to us, 'Oh, how do I go and do this?' 'How do I do that?' They really pick on our knowledge of the community, but we don't get any benefit from it. When we go for our funding round, they're using our knowledge to apply for funds against us. (Edward)

In this way, service coordination and knowledge impacted negatively on the ability for Edward's organisation to be able to provide their services effectively (and at all). As a result, coordination could be treated with suspicion.

The uncertainty attached to funding not only led to feelings of mistrust, but also impacted on the ability of service providers to make any plans longer than three years, or the length of their funding. Ben had long-term plans for the not-for-profit, member-based youth organisation, which included a separate drop-in centre for children who did not necessarily want to do a specific activity, but simply wanted a safe space to relax:

Part of that plan is a drop in area, we're going to build it at the back our club. So that, that should be a pretty exciting times.... At the moment, when they do sometimes come in for drop in, we will have to say, 'Oh, no drop in today due to we got a activity in that room'. But, with this area at the back, it'll be solely just, just a drop-in centre area. (Ben)

However appropriate this plan though, its fulfillment depended on whether funding could be secured to build the infrastructure needed. Here, Ben acknowledged that plans longer than the funding time were more a dream than reality, with significant time needed to spend on the actual writing-up and submission of the grant itself, where success was not guaranteed:

It would be good to be like that, you know, have everything - all your plans in place and have this beautiful club that's going to cater for the community.... You know, you've got to chase a grant to make that, to make that goal happen... So, being a not-for-profit organisation with, you know, we're, we're sort of just managing to just get through each year and providing for what we need.

Another service provider felt trapped in the same cycle of incremental planning, where longer-term infrastructure needs rarely fell under a funding opportunity. He argued that winning grants did not solve these very practical infrastructure issues:

Yep, we win this contract to do XYZ, but overall we might want to do this other, bigger picture and you can never... Like this shed is an example, if we were just sitting here doing our program, we would never be allowed to put money aside to build this. So, you're sort of very... It's defeating your purpose in some ways, as an organisation you could grow by bring more programs into it, but none of those program funds have money to build your infrastructure. So, you can't grow as an organisation. We would sort of be at our sort of capacity now. We may win other funding but we haven't got anywhere to put any staff. So, we haven't got anywhere to run the program out of. (Edward)

There was an implication within this funding narrative that there were two sides of an organisation that needed to be funded: 1) the programs and services, and 2) the infrastructure from which these programs and services could be delivered. Both were needed in order to successfully implement programs and services, but only the first seemed to be included in funding opportunities. While the Mayor offered peppercorn rents to some, even the most basic space cost money:

The government, or whoever provides the funding has got to realise that if we want to do capacity building in the community... So, I guess if we want parents with kids at 0-8 to be able to improve that part; there's got to be a place where you can go and those places are getting more and more limited. So, unless you go to a government TAFE or an organisation, such as a big multinational, you're not sort of fulfilling smaller community needs. (Edward)

Further, this lack of ability to plan forward impacted on the ability for organisations to deliver their services at all. Engagement with the Aboriginal community in the Moree Shire was argued to take time that was often not initially considered in the initial funding program; an issue that has been considered in other community-embedded research and service programs. Engagement is based on trust and interaction between people that necessarily needs to go beyond funding restrictions of timelines and trust, once broken through a loss of funding and the discontinuation of a program, can be difficult to repair:

And, it breaks down the engagement. Like you might be building up an engagement with an Aboriginal community and then, all of a sudden, your funds run out and then, all of a sudden, their expectations that we are still providing the service, is still here. They come to Club and but that service is not there because the money is dried up, so basically, then all of a sudden you got to explain and say 'No, we can't run that anymore, the funding's gone'. Then we got... Then, we got to start all over again. (Ben)

Here, there was a sense of just how important continuity of funding was when providing services and programs to people who are vulnerable to adverse physical and mental health conditions, and require support outside of mainstream constructs.

In addition, a lack of certainty around the continuation of funding, and in what form, meant that the staff of these services and organisations were also uncertain as to whether they would have jobs beyond the funding. There was also concern as to whether an organisation would have adequate staffing. There were struggles to both find funding to employ people for an adequate number of hours, or to allow for necessary positions. These gaps in the funding impacted negatively on how the service was delivered, as there simply were not enough people (employed for enough hours) to do it:

You know, you might be able to provide them with five hours here and, you know, maybe ten for a week. I've got administration here that I employ for over 30 hours to assist me, but other than that, everything else is just small blocks. And, really, I think if you're going to make a dent in the community, we need that full-time Engagement Officer in the club all the time, to deal with the children as they come in. You know, that way, they can really point them in the right direction.... There was an opportunity for some funding last year for an Aboriginal Engagement Officer. And that would be the ideal one to get in the Club, but, the funding didn't come our way. We probably had, I think, about 20 or more support letters from different agencies around town, so there was plenty support to have it. But, yeah, I suppose, we targeted that funding, we...it never happened. Yeah, I suppose, it is a part of our vision. We do want one.

(Ben)

The inability to employ suitable staff was also discussed by other service providers. Maria and Edward explained that the Aboriginal Youth Service they managed ran a program to better facilitate positive and nurturing family experiences. They trained parents who could then become mentors to the next group of parents, thereby creating a positive community of practice. The program also involved young children as well to ensure they felt included within their classroom as there was a sense that Aboriginal children often lacked confidence when they attended school: "just to see little Murri kids going to school and not actually struggle...to be confident enough to put their hand up and answer the question in class" (Edward). However, parents who had completed the program could only mentor if the funding continued – without this process, a community of practice would not be created. While two or three parents had been employed over the two years of the program, Maria described the uncertainty felt by the parents:

... every year that I take on new enrolments, I have to employ tutors who are parents on the program, so it's creating employment but it is only for two years. Our first, because we only started last year, our first parents who are on the program, this is their last year employed, and that is what they're saying, 'Can't you keep us... you know, or find, create a job here for us to do or something?' It's a bit hard. (Maria)

However, this uncertainty did not just impact the parents wanting to work with the Aboriginal Youth Service, it also impacted on potential participants as well. Edward argued that the perceived success of the Aboriginal Youth Service meant “the community has seen that, ‘OK, look, some of those parents have got jobs out of it. There is an expectation that if we had the program in next year, I might be able to get a job too.’ If it’s cut off, then that stops people”. Consequently, the positive community of practice building through the Aboriginal Youth Service would be halted if other parents did not participate in the service due to this uncertainty.

This damage to the positive community of practice being built by various services and organisations was also noticed by the Mayor who was very much aware of the difficulties connected to a competitive grant environment:

...it’s soul destroying as you get people doing a fantastic job in something, and the funding’s cut and they think, ‘Oh’, they don’t value themselves. And that’s bad, bad for community if you’ve got people who aren’t valuing themselves. (Katrina)

As a result, services did what they could with what they had, as the ability to change for the better (or simply to try something new) was out of their control as it depended on funding, and the requirements of the funding. As with all funding programs and grants, service providers spoke about how their funding was targeted which restricted and bound what they could spend the money on. Edward argued that funding bodies

...say they’re flexible, until it comes to the point where you say ‘I want to spend some money on it’, and they go, ‘No, you can’t do that’. Or, ‘Here’s a section of the community that we are not able to target. We want to target them. Can we have some additional funding?’ ‘No, you’ll have to do it within the money you’ve got’.

Edward saw gaps in the community, but which he could not fill with the funding he had at that moment. Filling those gaps would take another successful grant application. However, given that these services were located in a predominantly outer-regional area of New South Wales with a small and diverse population (see the literature review chapter), another significant concern was whether the funders understood that their region was different to one in a major city. Here, the negative impacts of media coverage by city newspapers (examined

in the literature review and in the first section of this chapter) lingered. If the city-based funders only saw these negative reports of the community, would they understand the lived experiences of the Moree community in terms of access and inclusion issues relating to children aged 0-8 years? Edward worried that the expectations placed on their funding was not necessarily appropriate to community context:

And also, the contracts that you receive might have the same outcomes that someone in Sydney's got, or that someone from another part of Australia has got, which is not really specific to what we want to do or the needs of our community are here. You have someone who doesn't live in our community setting our guidelines and our outcomes for our target. (Edward)

In this way, service providers' perceived lack of communication could be linked to their own insecurity and uncertainty attached to funding. As has been mentioned earlier in this report, this seems to be a direct issue with many service providers only being able to employ staff on short term contracts of maybe one or two years duration. This is a direct result of grants or other funding usually being only a few years duration making longer term planning problematic. Here, the uncertainties attached to the ability to maintain staff amidst these uncertainties also linked with the discussion had by some of the preschool and primary school teachers and principals around the emphasis on training and the impact this has on being able to appropriately support children aged 0-8 years of age. Certainly, Rosa from Preschool-1 worried that some services would need to be proactive in ensuring all children were able to access and be included in all the services that they needed. This not only meant greater staff training, but coordination among organisations as well:

The up-skilling of staff is one of our priorities, especially with the NDIS coming in. I think there is going to be a lot of pressure on those services. Still I am not sure whether or not there will be kids that fall through that gap. That won't fit the criteria for NDIS. And that is one of our priorities for making sure that service providers have got the skills to actually provide the appropriate support for the all the kids. (Rosa)

While the issues described by the parents of children aged 0-8 years with additional support needs cannot be dismissed, it is also important to recognise the community-embedded work undertaken by the service providers in the community, particularly the participants in

this study. There was a sense within the narratives that, as service providers balanced funding applications and actually running the services, there were “a lot of people out there that do a brilliant job and get no accolades for it...” (Katrina).

The Small Things With Big Impacts

Some of those organisations (and facilities) which provided appropriate support with few accolades (and thus less chance for funding) were ‘small’ in the sense that they either began as someone simply wanting to help out in the community, or were something that might not be seen by others who did not have issues around accessibility or inclusion, particularly by those who lived outside the community. They may have been small but, within the participants’ narratives, they made a big and positive impact.

The other two ‘small’ things mentioned were not services per se but rather linked to the lived experience of feeling and being included in the community. First, as explored in an earlier section, the broken wheelchair accessible swing hindered the inclusion of a child who used a wheelchair. While the park was ostensibly an accessible space for him, the continuing disrepair of the wheelchair accessible swing meant that he could not be included in the play of the park space like the other children. This would have isolated him even more. While a seemingly ‘small’ thing, the lack of a wheelchair accessible swing had significant impacts for the child who needed it.

Second, and again as explored in an earlier section, there was a perceived need for somewhere to go out to eat that was child-friendly and accessible. A small café in the centre of the main street, was mentioned as an accessible place to go but it was only open during the day and did not have a separate play area for children. As Becky explained, the pub had good meals and a play area but was only appropriate on certain days of the week, given its other patrons. Here, there was a need for families, particularly with children aged 0-8 years with additional support needs, to feel included in the community in terms of recreational activities, not just health-related services.

Chapter 4: Recommendations for Future Directions

This study sought to answer two research questions:

1. How are issues of access and inclusion experienced by children (aged 0-8 years) and their families with regards to services (including schooling) and infrastructure (including parks and social activities) within a rural NSW community?
2. What challenges exist with regards to developing and providing accessible and inclusive services) in an outer-regional NSW town?

The findings from this study are important in that they not only provide answers to these questions, but they also give voice to a community (and specific members of that community) who may often not be heard. As mentioned by one of the participants (Edward, a service provider), funders tend to be from metropolitan areas where the way of life is not the same as that experienced in more regional and remote parts of Australia – access to myriad services and infrastructure is not the norm in Australia’s very remote communities. In this way, it was important to include the voices of community leaders, Aboriginal Elders, service providers, and mothers from an outer-regional community in Australia.

These narratives (as explored in the previous chapter) demonstrate the interconnected, interwoven, and complex ways in which children aged 0-8 years are (and are not) included in the Moree community, particularly when they have additional support needs. While the voices of the children themselves were not able to be included in this study, the focus remained solely on the children and, as such, the participants became advocates for them. This was particularly the case for the mothers. While everyone recognised this group to be both important and vulnerable, they also recognised that there were no easy answers to the challenges facing these children in seeking accessible and inclusive support and activities. Further, while undoubtedly interwoven, each group of participants saw the issues around these children in very different ways. For example, some issues were only mentioned by the Mayor, arguably because she needed to see a ‘big picture’ of the community. In contrast, the parents of children with additional support needs spoke about the challenges of access and inclusion they felt in everyday life. Funding issues were high on the minds of some groups, but only seen in terms of fewer services and activities (and a lesser quality of life) by others.

In light of the findings examined in the previous chapter, there are several recommendations for future directions to be made. Many of these recommendations have implications for practice that should be considered by services as they continue to work in Moree.

1. There is a need to understand what organisations exist in Moree and the services they provide

Within the stories shared by the parents and the service providers, there appeared to be a significant disconnect. Parents (and the Aboriginal Elders who were grandparents) did not know enough about which services existed, and what they did. Services did not coordinate well between themselves (for various reasons, as described in the previous chapter), and there was no sense as to whether there were overlaps and which children may have fallen between the gaps.

Implication for practice: Services in the Moree Shire need to be mapped to gain a true sense of what exists and who is being supported and how. This type of mapping would also identify overlaps and gaps. As one of the leading services in the region, Northcott could take a leadership role in the coordination of this process. This can be done in coordination with other services, inviting them to join to ensure all services are identified in the region. Once the mapping is finalised, Northcott and the other services, should present their findings in a community setting, inviting service to learn about all the services available. This could take the form of a community meeting and/or the range of services being well and permanently advertised in the community.

2. There is a need for greater coordination of services in the Moree community

There are reportedly 68 separate services being provided in Moree with study participants indicating that it was difficult to know what services were actually available in the area. This was also reported by the some of the service providers, suggesting a possibility of overlap of services, and services, which are not being targeted into appropriate areas of need.

Implications for practice: There is a clear need for a position to be created for coordination of the services in Moree e.g., a Coordinator of Support Services. This position would have the

responsibility of ensuring that services are coordinated and well promoted to the community. The Coordinator of Support Services role would support both service providers and users and the most logical place for the position to exist would be through the Moree Shire Council administrative structure.

3. Funding to services needs to be ongoing

It has been stated by the Mayor that there are 68 separate services and organisations in Moree and, as is stated in Recommendation Two above, there are issues around effective provision. Linked to this issue is that service providers have to employ personnel in order to operate effectively. Usually those services employ local people and, as has been discussed in this report, there may not be enough qualified staff for the positions. The main point is that the funding of the services, either from government or elsewhere, tends to be one or two or, occasionally, three years. The problem with this type of model is that most staff (outside very large state or national providers) will be on temporary short-term contracts in relation to the period that the funding is for. Staff will always be looking for security in employment and, therefore, there is a reported problem with not being able to retain staff, thereby causing difficulties for projects.

Implications for practice: A potential solution to this issue is that longer term funding models should be employed so that staff will have more job security and that providers can plan for at least the medium term instead of almost immediately (from award) beginning to consider the issue of continuation of funding. If longer-term funding is not available, managers within services can support those staff in short-term employment through regular debriefing, as well as ensuring that they gain skills useful in later employment. Further, training staff in grant writing may also be useful as a way to succeed in future grant opportunities.

4. Funding needs to also include infrastructure

Again, tied to the recommendation above, funding needs to not only be considerate of staffing, but it also needs to be more pragmatic in its application. As discussed in this report, funding tends to cover the development and delivery of programs, but it often does not stretch to include where those programs might be delivered. This very practical issue becomes

important in regional and remote Australia where there is less infrastructure to begin with and, when buildings begin to decline into a state of disrepair, there are few options to move so services must make do with what they have. However, as also discussed by service providers, this can negatively impact on the quality of the service delivered, its accessibility, and (sometimes) whether it can be delivered at all.

Implications for practice: There needs to be acknowledgement by funders that funding infrastructure is just as important as funding the programs delivered within its walls. However, as the majority of funders are located in metropolitan areas, organisations located in Moree Shire need to collaborate to create a document detailing this disconnect in funding. This document could be first delivered to local government, and then to state and national government, as well as the funding bodies themselves.

5. ‘Disability’ needs to be understood in all its variations and nuances

The parents included in this study either had children with intellectual and/or physical disabilities or children on the autism spectrum. These different disabilities necessarily required different and additional supports. It was not enough that a playground be physically accessible – its play-things needed to be appropriate (and unbroken) for the children who used the playground. In this way, there was a need for children with sensory needs to have a safe play space, and there was a need for children with physical disabilities to have areas and toys that were accessible. As one parent pointed out, there may have only been a few children who needed the wheelchair accessible swing, but it made all the difference for them when it was gone. They now had nothing to play on in the playground.

Implications for practice: Ideas around access and inclusion need to be considered in more than just numerical terms, but on how a child’s quality of life has been, and will be, affected. The 0-8 years of age period is one that is crucial to a child’s development and wellbeing and thus they need to be supported during this important and vulnerable time to allow them to grow to their fullest potential. As a result, part of the Coordinator of Support Services role (see Recommendation 1) should be to identify such gaps in the Moree Shire and work with community members, to discover what would most appropriately fill the gap, and with local government to implement these changes.

6. Accessibility and inclusivity is not just bound to health, but to quality of life

While access to healthcare featured significantly in the narratives of everyone within the study, a second significant narrative was around access to, and inclusion within, social events and infrastructure. However, seemingly simple activities – like a family dinner out or a trip to the cinema - were difficult to access in Moree Shire. The nearest cinema was a one-and-a-half hour drive away - a three hour round trip. Coupled with the time of a movie, this excursion became almost impossible for children with autism, particularly. It was simply too long for them to remain comfortable. Eating out was also problematic as the only local restaurant with a space for children to play was a local pub, where patrons could become rowdy.

Implications for practice: Here, it may not be what services in Moree Shire can do themselves, but how they can act as advocates for service users, particularly the Coordinator of Support Services. Part of their role could include searching for events that could travel to the region. For example, while establishing a stand-alone local cinema may not be within council budget, there are opportunities for events like Cinema Under the Stars, which could be brought to the community on a regular basis. Further, there is an opportunity for small, local grants to be made for restaurants and cafes to create spaces for children (or even simply provide paper and crayons at the table) as a small way to make more local establishments child-friendly and thus allow parents to be able to enjoy social moments within the community. Again, this is where training in grant writing could provide significant benefit. These may seem like small things but, as has been explored throughout this report, they can have significant positive impact.

7. The Need to Improve Access to therapy services in a rural community

Access to health services in a rural community has been described in the literature (and in this report) as problematic. Providing the level of service required for people who are located away from urban centres seems to be fraught with challenges, most notably staffing and transport. Participants in this project specifically mentioned a lack of access to follow-up therapy, usually after having seen a specialist or paediatrician. Access to follow-up therapy can be crucial to the development of a child and missing sessions due to a lack of access or personnel will most likely detrimentally affect the child and family.

Implications for practice: With the roll out of the National Broadband Network (in Moree Shire this should be completed by the end of 2017), access to services such as ‘telehealth’ should become all the more common and communities such as Moree should be actively considered for this type of service delivery model. Therapy assistants could also be employed, from the local community, who would undergo limited training, but would be under the ‘remote’ guidance of a qualified allied health practitioner such as a physiotherapist or an occupational therapist. Again, the Coordinator of Support Services could ensure that everyone is aware of, and has access to, these new technologies and services as they become available in Moree Shire.

Despite the hardships of drought and other environmental impacts, and its lingering negative perception, Moree is a community that continues to strive towards creating and maintaining a strong and positive way of life for its residents. This study focuses on members of the Moree community who have not always been able to have a voice in the decisions made for them. It is hoped that the findings from this study, and the recommendations drawn from the participants' narratives, inspire positive changes and create a more accessible and inclusive community for all those who live in Moree.

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Appendix 1 – Interview Questions

Service Providers:

1. As a service provider how are you providing a service that is inclusive and accessible?
 - a. Does the funding that you are given to run your service/school have defined criteria on how to provide the service and who is able to access/engage with your school/service? Does this criteria restrict the delivery of the service ?
 - i. If so, what would be a solution to this?
2. How does your service/school cater for the 0-8yr age group?
 - a. Do you tailor programmes for students with additional needs?
 - b. How are children with varying abilities included in your service/school?
3. What activities, if any, does your service provide in the Moree community which promotes inclusion?
4. What services do you think work well in Moree?
 - a. What is it about that service which works well? (name not req)
5. What do you believe is missing or is not effective in service provision and the school system within Moree?

Families:

1. Do you feel included in the community, (for example do you feel comfortable when going out as a family, e.g. access to services, shops, sporting & social events?)
 - a. If 'no' why not?
 - b. If 'yes', why?
 - c. Is cost a factor?
 - d. Is transport a factor?
2. Do people know what services for 0-8 year olds are available in Moree and /where/how to access these services?
 - a. If not, how could providers better communicate their service to the community and families?
3. Have you accessed any support services either currently or previously?
 - a. If so, what is the service providing?
 - b. Do you feel supported and is the service meeting your needs?
 - c. Have you noticed any barriers to accessing the support?
4. Are there appropriate facilities for children 0-8 and their families with disabilities/support needs to access services (e.g. wheelchair access to shops or transport)?
5. Do young families have places to go or facilities to access?
 - a. If no, what facilities would your family like to see in Moree?
6. From the perspective of your child or children (0-8) are there services and facilities available for them to access?
 - a. If so what are there?
 - b. What would they see as being needed?
 - c. Do you think they feel included?

Elders:

1. Do you feel included in the Moree community?
 - a. If not why? Please provide examples?
 - b. How could this be changed for the better?
2. Do you feel your family members in the 0-8 age group are included in the Moree community?
 - a. If not why? Please provide examples?
 - b. How could this be changed for the better?
3. Do you know what is available/where/how to access various services in Moree for the 0-8 age group?
4. What services do you believe are missing, if any in the community for the 0-8 age group?
 - a. Are there appropriate facilities for people with disabilities/additional support needs to access services (e.g. wheelchair access to shops or transport) for the 0-8 age group?
 - i. Please provide examples
5. Are you aware of the support services in the community for children 0-8
 - a. If so, is a family member accessing any of these services currently?
 - b. If not, how could providers better communicate their service to the community?

Mayor

1. As a Shire Council how are you providing facilities / supports to the local community that are inclusive and accessible for children 0-8yrs and their families?
2. When planning community events how does the council cater for the 0-8yr age group and ensure inclusion for children of varying abilities?
 - a) What activities/events does the council organise which caters for this group?
3. What facilities/supports would you like to see in Moree for children 0-8yrs.
 - a) Is there anything you as the Mayor of Moree or the Moree community as a whole, could do to attract these services into the township of Moree?
4. Are there any barriers in Moree that may prevent services/organisations/facilities/council from being accessible and more inclusive for children 0-8yrs?

The researchers would like to thank you for the time you have taken to participate in this research.